RN

A JOURNAL FOR NURSES

NOVEMBER 1940

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IN *This* ISSUE

November 1940 Vol. 4, No. 2

A JOURNAL R.N. FOR NURSES

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Debits AND CREDITS

PROBIE

Dear Editor:

Congratulations on your new cartoon feature! "Probie" reminds us of those early days when we were all hands and feet and the coveted R.N. seemed to wait at the end of eternity.

May we have reprints of the series?

R.N., Cleveland, O.

[*Do other readers want reprints suitable for framing or mounting? If enough requests are received,* R.N. *will offer a set of the first six cartoons in the series for ten cents.*—THE EDITORS]

RED CROSS

Dear Editor:

Last month you sent us a proof of an article entitled "Defense Begins at Home," and asked me to make any suggestions or corrections before the article was published. We were so long in answering your letter that the article appeared without our suggestions. I am, therefore, writing to ask you to print the following comments in the interests of accuracy.

The American Red Cross is encouraging enrollment of *all nurses who qualify for the first reserve,* not of "all nurses," as your article states. In the list of qualifications, it should be mentioned that "single" status includes women who are widowed or divorced. Regarding the number of reservists needed, the national nursing organizations have estimated that about 20,000 nurses eligible for the first reserve graduate in any one year. At least 10,000 of these newly graduated young women should be enrolled in the first reserve of the Red Cross . . . The third reserve is composed of nurses who are not only inactive (as your article states), but who have failed to supply essential information, such as change of address.

When the national nursing census is taken, the details of the qualifications of all nurses in the country will be listed in order that each may be available for the service which she is best fitted to render her country at that time.

Through enrollment in the first reserve of the Red Cross, nurses are assigned to either the army or the navy. Nurses who indicate their preference for the Navy Nurse Corps are accepted for appointment to the Naval Reserve Nurse Corps upon completion of the application blank, authorized physical examination, and acceptance of oath.

Regarding base hospital units, the Surgeon General of the United States Army is asking the directors of certain large hospitals throughout the country to organize, on paper, a medical unit, which will correspond to the old base hospital unit of 1918. A unit includes about 120 nurses. Nurses must be members of the Red Cross first reserve, since these units are organized under army standards.

Your information on home hygiene courses is not quite accurate. Graduates of courses in Home Hygiene and Care of the Sick are not prepared to work in hospitals.

Mary Beard, R.N.
Director, Nursing Service
American Red Cross
Washington, D.C.

[*Thanks to Miss Beard for her interesting letter amplifying material published in* R.N.'s *defense story last month.*—THE EDITORS]

NAVY RECRUITS

Dear Editor:

In regard to your article, "Defense Begins at Home," the procurement of navy reserve nurses is from the Red Cross reserve. It is true, as your article states, that it is possible for a nurse to apply direct to the navy, but this procedure is not practised to any degree.

Sue S. Dauser, R.N.
Supt., Navy Nurse Corps
Washington, D.C.

CAPS FOR MEN

Dear Editor:

Have you heard there's a movement afoot on the Pacific Coast to make men nurses

Mennen Antiseptic Oil is pleasant to use, leaves no greasy residue. Non-irritant, self-sterilizing, won't turn rancid.

BODY-Guard NEEDED

For at least 12 to 14 months

Constant danger of skin infection . . . . that's what babies face all through and even past the first year. That danger is *ever-present,* because the baby's delicate skin has comparatively little *resistance* to germs.

To help keep baby's skin *safer* from germs, the majority of hospitals—*over 3800 of them*—use Mennen Antiseptic Oil routinely in their nurseries, for removing the vernix, for the first antiseptic cleansing and for the daily antiseptic anointings. The oil *reduces the number of surface bacteria,* acts as a BODY-Guard that helps protect baby's skin against germs! Won't you impress on mothers the importance of continuing this protection at home by oiling baby's skin daily with Mennen Antiseptic Oil—*right past the first year?*

WARNING!

Please don't think *all* oils reduce surface bacteria! It has been proved that bacteria on the skin may readily multiply when ordinary oils are used, such as olive oil, mineral oil, cottonseed oil and many pharmaceutical oils. Impartial tests show that Mennen Antiseptic Oil is in a class by itself!

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Send me free professional samples of Mennen Antiseptic Oil and Antiseptic Borated Powder.

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wear caps? Idea is to distinguish us white-suited males from the M.D.'s and orderlies. Something on the order of the soldier's overseas cap is the design which has been suggested.

I can't get used to the notion of a man wearing a hat indoors under *any* circumstances. Is this a female "fifth-column" move to discourage men from entering nursing? Or to drive the few red-blooded males in the field out of it? Come, come now, girls!

Personally, if I have to wear a cap, I want it to be a real one. I'm six-feet-three, weigh two hundred pounds, and have a thick crop of curly hair. I think one of those little custard-cup numbers some of our sisters wear would be just my type. Just too cute for words!

R.N., Portland, Ore.

CORRECTION

Dear Editor:

May I call your attention to "Family Tradition" in the July issue.

The description of the picture notes that the eldest daughter, Mrs. Clarence Myers, is an alumnus of Bloomsburg Mennonite Training School. The uniform, cap, and pin are identical to the uniform of St. Luke's Training School in Chicago. She was Esther Waller before her marriage, St. Luke's class of '33.

Could I be mistaken?

Emma B. Morrow, R.N.
Palo Alto, Calif.

[*Mrs. Morrow is right.*—THE EDITORS]

SICK NURSES

Dear Editor:

I've been very much impressed to find that so many of your readers are contributing to a fund to pay for subscriptions to R.N. for sick nurses. This sounds like an awfully good idea. Orchids to the nurse in Washington, D.C., [Emma Sanford] who started the ball rolling.

Herewith is a dollar to add to the total. I wish it could be more.

R.N., Paterson, N.J.

[*Thanks to all the generous readers who have contributed! So far, twelve nurses have received paid subscriptions, $26*

No wonder Gruen is the nurses' favorite!

• The Gruen Veri-Thin, designed especially for nurses and doctors is, first, a supremely practical watch for on-duty wear. It is also a watch to do your social moments proud . . . dainty, exquisitely designed, superbly thin. Yet, thin as it is, its patented Gruen Veri-Thin movement provides large working parts for accuracy and long life.

Below are new Gruen styles for doctors and nurses. Gruen watches, at Gruen jewelers, from $24.75 to $250; with precious stones to $2500. Write for folder. The Gruen Watch Co., Time Hill, Cincinnati, O., U. S. A. In Canada: Toronto, Ont.

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D. VERI-THIN* AIRMAN, 15 jewel movement, yellow gold-filled case, Guildite back. $33.75

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*REG. U. S. PAT. OFF. PATENTS PENDING

GIFTS FROM YOUR JEWELER ARE GIFTS AT THEIR BEST!

remains in the fund. Names are taken from applications for new subscriptions which state, "Not actively nursing, due to illness." This service will be extended as long as the money lasts.—THE EDITORS]

P.N. THREAT

Dear Editor:

Your August editorial ["What It Takes"] was particularly interesting to me since a recent experience with practical nurses revealed the seriousness of the situation confronting us.

I am a public-health nurse and last Spring was hospitalized to check an early case of tuberculosis. Soon after I had been installed in this fine institution, I discovered that I was being cared for by willing and agreeable—but thoroughly incompetent—practical nurses. They used absolutely no technique to distinguish between positive and negative sputum cases. Although there were bathrooms connecting the rooms there was no provision made for hand-washing. One graduate nurse worked on the floor, which was supervised by a practical nurse.

The ACE Ankle Roller

in the treatment and prevention of athletic injuries

Your patients will be glad to know about the ACE Ankle Roller—a regular ACE Bandage in miniature—used when and where the regular 5½ yard length is longer than is convenient or practical. ACE Ankle Rollers are 2½ inches wide, 3 yards long when fully stretched. Natural white color, with soft feathered edges—or (where appearance is a factor) neutral flesh color, with flat woven edges. Prices, 50¢ and 65¢ respectively.

B-D PRODUCTS
Made for the Profession

BECTON, DICKINSON & CO., RUTHERFORD, N. J.

These women wore complete uniforms and the doctors in the sanitorium claimed not to have realized they were not graduate nurses.

Patients are sent to a sanitorium not only to cure but to learn as well. It is obvious that they will derive no benefit through association with these untrained women. Knowing how to bathe patients, take temperatures, and change beds does not qualify one to teach health. Consequently, daily valuable opportunities are being lost in the fight against tuberculosis.

R.N., Detroit, Mich.

Dear Editor:

I hope your journal will continue to discuss the subject of registered nurses vs. practical nurses, household assistants, and all other untrained women who wear white uniforms and call themselves nurses.

It is the responsibility of every registered nurse to help the public distinguish between trained and untrained nursing care. Our purpose should be to acquaint people with the importance of care by qualified nurses. We should not be interested in preventing practical nurses from working; but we should be interested in having them employed only on cases they are capable of handling.

The old saw, "a little knowledge is a dangerous thing," contains a lot of truth. Surely, a few weeks or months of the simplest form of nursing does not equip these women to function as nurses. There are plenty of subsidiary jobs they can fill, but the public should be educated to the fact that *they are not nurses* . . .

Jessie C. Drake, R.N.
Brooklyn, N.Y.

HOBBYIST

Dear Editor:

Please accept my thanks and appreciation for publishing my call for buttons for my collection. I have received about fifty replies, some with interesting letters and all from a variety of States . . .

Eva P. Smith, R.N.
Reading, Pa.

[*Other collectors are invited to use* R.N.'s *hobby corner which will be published as often as space permits.*—THE EDITORS]

IMADYL UNCTION
brings welcome warmth to painful areas

LOCAL APPLICATION of Imadyl Unction is indicated for the relief of pain due to metabolic disorders, such as arthritis, neuritis, and rheumatism. Simple massage suffices for effective absorption of the histamine, the chief ingredient, whose vasodilating action opens up the choked capillary network. The resultant increase in blood flow stimulates local metabolism, quickens the disposal of metabolic end products, and brings with it a delightful sensation of glowing subcutaneous warmth.

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ROCHE PARK • NUTLEY • NEW JERSEY

Pain-Relief Through Massage with IMADYL UNCTION 'ROCHE'

CANNED FOODS AS SOURCES OF THE ESSENTIAL NUTRIENTS

● Early in this century, the existence of "accessory food factors"—the vitamins—was demonstrated by animal experiments (1, 2). Since that time, building upon information established by earlier investigators regarding the calorie, protein, and mineral needs of man, contemporary workers have developed a practical and fairly complete working knowledge of nutrition. At the present time, the fundamental human dietary requirements are considered in terms of some thirty substances of known chemical composition plus a number of factors whose chemical natures still await determination (3). Likewise, the dietary values of foods also may be discussed in terms of these same essential nutrients.

Viewed from a physiological basis, nutritional failures appear to be conditioned either by consumption of a diet deficient with respect to certain of the essential food factors or to altered processes in metabolism which prevent the efficient absorption and utilization of foods (1). Failures of the latter type can be corrected only by elimination of the defects in metabolism, or by administration of nutrients by routes which permit utilization. However, the vast majority of nutritional failures are associated with the consumption of diets deficient with respect to essential food factors. In the following quotation, the facts regarding malnutrition resulting from faulty diet are concisely stated (1):

> "Three facts concerning nutritive failure are becoming increasingly obvious: first, that it does not come solely from lack of vitamins but from deficiency of proteins and minerals as well; in certain of the lower animals, it comes even from lack of fats; second, that in America it is seldom complete; and third, that it is not, as a rule, the expression of a single nutritive fault. More often it is partial in extent and multiple in nature, with a clinical picture that is correspondingly lacking in detail and hazy in outline."

Although nutritional diseases are manifestations of the prolonged consumption of diets deficient with respect to amino acids, minerals, and vitamins, students of the problem agree (2, 4, 5, 6) that elimination of malnutrition is primarily a problem of increasing the variety of foods regularly eaten. Special emphasis should be placed upon the judicious consumption of familiar foods such as meats, (including glandular organs, poultry, sea food, and fish); eggs; milk in its many forms; milk products; fruits and vegetables; legumes; and the whole cereals and their various products. Thus, in its practical application (7), nutrition may be viewed as "an economic, agricultural, industrial and commercial problem, as well as a problem in physiology."

The nutritive values of canned foods have indeed been well established by means of numerous studies (8). By transforming foods, from the perishable condition in which they are harvested, to canned foods which may be stored for consumption in all seasons, the canning industry has rendered great assistance in carrying out the program designed to eliminate malnutrition in America.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

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We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-fifth in a series, which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

QUICK FACTS ABOUT GONORRHEA IN THE FEMALE

Ted F. Leigh, M.D

• Unlike syphilis, gonorrhea has been known for centuries. It was described by Galen and other early physicians, although its true nature was not recognized. Shortly after the widespread dissemination of syphilis over continental Europe in the early Sixteenth Century, the two diseases were regarded as one. In 1879, Neisser identified the causative organism and thus the preexisting state of confusion was clarified.

What is gonorrhea?—Gonorrhea is an infectious disease, spread almost exclusively by sexual contact. Extragenital transmission is rare, although it has been traced to infected towels or douche tips. The causative organism is a small diplococcus, that is, it is usually seen in pairs. Since the coccus is slightly elongated, it has a coffee bean appearance. It is gram-negative in its staining qualities, a characteristic which serves to distinguish it from other diplococci. The organism can survive only in the moist state and is readily destroyed by drying, mild heat, and even by mild antiseptics. It is grown with difficulty and only on culture media which contain human blood. According to many authorities the gonococcus is not infectious for any lower animal.

Two features of the gonorrheal infection serve to explain its chronicity and the difficulty with which it is eradicated. The gonococcus, upon being implanted in the vagina, remains on the surface of the mucous membrane. The

pus-laden semen is probably distributed to all portions of the vaginal vault and the introitus. Within one to three hours the gonococci, in the process of growth, enter the many glands of the cervix and the other glandular structures of the vagina; they also enter the urethra and burrow into the urethral mucosa. Thus, within a short time, the micro-organisms are no longer accessible and topical application of antiseptic agents cannot prevent the progress of the infection.

After the infectious process has run its course and has subsided, some gonococci remain viable in the tissues, and are presumably capable of maintaining this dormant state for as long as a year. During this period, parturition, sexual excess, a weakened physical condition, and probably alcoholic excess may lead to an acute flare-up which resembles reinfection. Many cases of acute gonorrhea can be traced to this source and many persons have been wrongly accused of transmitting the disease. This situation frequently arises shortly after marriage, when one partner may suddenly develop gonorrhea from the other and be accused of illicit relations, even though the responsible partner may show no signs of his or her latent gonorrhea.

Gonorrhea, like every other infectious disease, varies in its intensity, a factor which depends upon the virulence of the organism and the resistance of the host. In women especially, gonorrhea may produce such mild symptoms that no special notice is taken of its presence and no medical treatment sought. Hence the infection may be spread without knowledge by the responsible person.

In the female, gonorrheal infections may be divided into two groups: (1) those involving the structures in and about the vagina, and (2) involvement of the fallopian tubes and pelvic peritoneum. In the lower genital tract, the urethra, cervix, Bartholin's glands and Skene's glands are involved. In the adult, gonorrhea does not attack the vaginal mucous membranes; but in the vagina of young girls, where the mucosa is less thick and is not cornified, the infection usually is most intense. Skene's glands are two small structures whose ducts open one on each side of the urethral orifice. Bartholin's glands, also two in number, are located in the labia minora and the duct of each opens on the inner surface of the labia.

Estimates as to the frequency of gonorrhea in women vary considerably. It is believed that gonorrhea is responsible for one-half of the sterility seen in women, and that it necessitates one-

U.S. Public Health Service

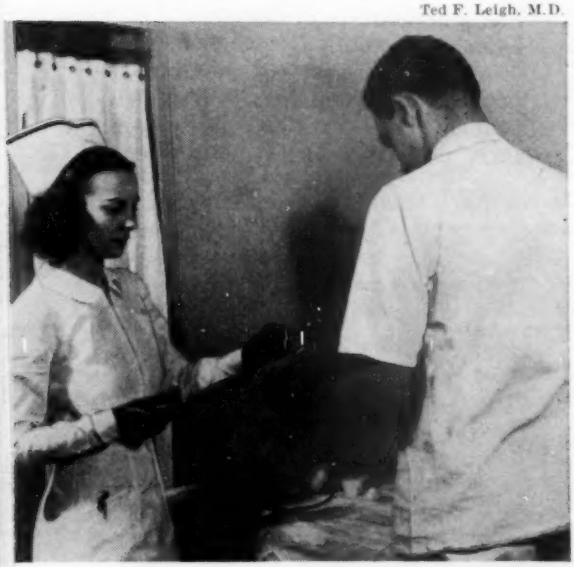
Recently the technique for culturing the gonococcus has been greatly improved. Here a laboratory assistant inoculates a culture with material from a suspected source.

half of all pelvic operations. Before prophylactic measures on newly born infants were required by law, gonorrhea accounted for 20 per cent or more of all blindness.

The incubation period is said to be from three to seven days. In women this may be difficult to ascertain because of the mildness of symptoms. Any or all of the vaginal structures may become involved; pelvic infection is always preceded by involvement of the external genitalia, but does not invariably occur. However, the urethra and the cervix are affected in all patients.

Symptoms.—The symptoms of acute gonorrhea in the female vary with the extent of the infection. Urethritis produces burning and frequency of urination, tenesmus, and soreness about the urethral orifice. A copious yellow-green discharge appears. Inflammation of Skene's glands does not usually produce any subjective symptoms. Examination discloses that the vaginal opening is fiery red, and the gonorrheal discharge can be seen in the various folds.

Ted F. Leigh, M.D.



Smears are taken from the urethra, cervix, and from Bartholin's and Skene's glands.

The openings of Skene's glands appear as two red dots located on each side of the urethral orifice. Pressure on the urethra exerted through the vagina causes pus to exude from the meatus and from the duct orifices.

If the gonococcus invades Bartholin's glands, the typical infection follows. Abscess formation is not uncommon, producing swelling and pain. The discomfort may be so severe as to make walking difficult. Pressure on the gland causes pus to appear at the duct opening. Only one Bartholin's gland may become infected, and this may not occur for several weeks after the gonorrhea is acquired.

Cervical gonorrheal infection occurs almost invariably. Although no subjective discomfort is produced, examination reveals that the cervix is bright red, edematous, and is covered with pus. The vaginal vault may also be red, and is usually filled with a mucopurulent secretion.

All acute gonorrheal infections run a relatively short course if untreated. A chronic stage sets in after several weeks. The characteristic purulent discharge is replaced by a mucous type of secretion. However, the organisms remain alive in the invaded tissues, hence the secretions are actively infectious. Chronic cervicitis produces a copious leukorrheal discharge. Bartholin's gland infection may lead to cyst formation, and a chronic urethritis is characterized by a mucous discharge.

Confinement of the infection to the lower genital tract depends upon many factors: the virulence of the infection, resistance of the patient, institution of treatment, and the time of the next menstrual period. During menstruation, opening of the cervical canal permits the organisms to gain easy entrance into the uterine cavity whence they rapidly travel to the tubes. It is important that patients with gonorrhea receive special instructions prior to the menstrual period. [*Continued on page* 46]

IS *Your patient* DEAF?

Handling the deaf patient, says Dr. Frank, requires special skill and insight. His own deafness gives him the opportunity to write with the authority of first-hand knowledge.

BY L. K. FRANK

• A nurse I know, vacationing in a small country town, was asked by a neighbor what should be used for an infected toe. Miss Stewart naturally advised the woman to see her physician and added, "Boric acid is always safe until you can reach a doctor." The inquirer thanked her and went off downtown. An hour later she was back and said, "My doctor was out, so I got some medicine for my foot. But how do I use it?" She unwrapped a small vial and held it up for the nurse's horrified inspection. The label read "Carbolic Acid."

This incident, besides illustrating the dangers of offhand prescribing, illustrated also to my nurse friend the fact that deafness is much more common than is obvious to the eye, for it turned out that the woman with the foot infection was hard of hearing and had therefore not correctly understood Miss Stewart. She had heard the "acid" plainly enough, and the "bo" and "ic" sounds in boric. But "r" is a difficult sound for the deaf, and the woman—depending on a typically inadequate lay knowledge of pharmacology—had assumed that Miss Stewart had recommended carbolic acid.

Mark that "assumed." Deaf persons, rather than go to the trouble of making sure, are only too prone to assume that they understand a speaker when, in fact, their understanding is distorted or erroneous.

From the nurse's viewpoint, the deaf patient will fall into one of three classes: He may have been deaf since birth or infancy—that is to say, he may be a mute. He may have lost his hearing in childhood or youth, or he may be afflicted simply with the failing hearing of age.

The distinctions are important because the nurse's method of communicating with the patient will be governed according to the type of deafness. The mute makes no attempt to read the lips or hear anything, and the nurse is therefore reduced to communication in writing, or by simple signs. The lipreader may hear a little, but he depends on his lipreading ability for conversation. It is a great mistake to raise the voice when talking to a lipreader, for the increased volume of sound only confuses him and interferes with his visual efforts to understand what you are saying. Some deafened persons seem congenitally unable to learn to read lips and, with the elderly deafened patients, are those for whom the nurse must raise her voice.

When, as a youth, I was hospitalized with a severe brachial cellulitis, my nurse proved herself a jewel without

price in a very simple way: She was religiously careful not to touch the bed when I was trying to sleep. Absurd, you say? No, it's not absurd. A deaf patient abhors above all things to have his bed bumped, be it ever so slightly, because a contact with his bed is the one sure way of waking him. While an ordinary sleeping patient may be totally oblivious of heavy footfalls and the passage of the nurse close to his bed, the deaf patient is aroused instantly by such contact-vibrations. The auditory vibrations of a conversation in the next room or beside the next bed cannot disturb a sleeping deaf patient, but, figuratively speaking, he might almost be brought out of a deep sleep by the sound of a fly stomping around on his bed!

Miss Brown understood this, and it did not take her long to realize also that a hospital can be a lonely and upsetting place to a deafened individual. Out in the hall the carts were going by, to and from the elevator, and I could see orderlies and nurses hurrying along with fearsome-looking pieces of equipment. Ambulant cases from the children's ward would come into my room occasionally. While they ignored me and ate my oranges, they discussed among themselves, with what seemed to me an extraordinarily knowing air, all the small talk they had gathered out of the conversation of their elders. Even the kids knew more about what was going on around them than I did!

A deaf patient cannot become auditorily acclimatized to his surroundings with the help of a word heard here, snatches of conversation there. He just lies, and wonders what's going to be done to him, and whether his case is very bad, and what the doctor is saying to the nurse so seriously.

My nurse saw all this; she took time to talk to me and to explain away some of my unwarranted misgivings. She helped, immeasurably, the relationship between me and the doctor on the case. He was one of those individuals—"chest talkers" or "throat talkers"—who never move their lips when speaking. When he found I could not understand him, he raised his voice, and this made things worse, for Stentor himself could not make a lipreader hear words as understandable words. Since shouting did not work, the physician lapsed into monosyllables and probably blamed me for refusing to pay attention! Miss Brown took upon herself the duties of interpreter and thus eased the strained atmosphere. She knew that the whole trick of talking to a lipreader lay simply in pronouncing every one of her words firmly and clearly.

She soon caught on to other niceties. She was always careful to face me fully, and to see that I did not have to watch her lips with the light in my eyes, or with her face in a shadow.

A deafened person becomes accustomed to the brusque impatience of most people toward his disability. Hence, it is always an agreeable surprise to meet a stranger who will actually talk to one as to an equal. Too many people, when they are required by circumstances to talk to the deaf, display a condescending or patronizing air, but I have never met a nurse who took this infuriating attitude.

The nurse who draws the duty of caring for a young deaf child is going to need every bit of patience she can muster. Probably she will have to muster more than she had dreamed she possessed. For she will be dealing not only with the natural cantankerousness of a sick youngster, but also with the contrary guile of a patient who has been spoiled in greater or lesser degree by understandable parental indulgence.

A deaf child understands only what he wants to understand, knowing as he does that he can retreat from responsibility behind the shield of, "I didn't hear you." He may be bluffing.

but his attitude says plainly enough, "You can't prove I'm bluffing." And you can't. At least, not to *his* satisfaction. The nurse called for such a case must show the child who, to put it bluntly, is boss. This can be done in a kind, and yet firm, manner that will win his respect. Thereafter he will do things for her that he would not do even for his mother, for he has always been able to buffalo his mother.

Aside from contrariness, however, the young child cannot be expected to be a very competent lipreader, since lipreading is an art that requires a lifetime of practice. The nurse's ingenuity must be depended on to suggest simple signs and expedients that will help to make her meaning clear to her young patient.

Every nurse has met victims of the failing hearing of old age. This type of deafness will become increasingly common in ratio to the increasing percentage of older people among the population. In a sense, this is the most tragic form of deafness. It afflicts those who can remember what normal hearing is, and who are now too old and inflexible to adjust themselves easily and gracefully to their distressing handicap. Some persons of this class will not admit that their hearing is failing, or permit others to suggest or discuss such a thing. The nurse who has such a patient will need to call on all her resources of tact and diplomacy. But in any case she should remember that clear, careful enunciation of her words is much more important than loud speaking.

The deaf always feel frozen out of any general conversation, and the kindest thing a nurse can do is to keep the patient informed and reassured, without seeming to, of all that transpires around and concerning him. For if she does not, who will bother to do so?

PROBIE

"Look Miss James—409 wouldn't eat his lunch."

Relax

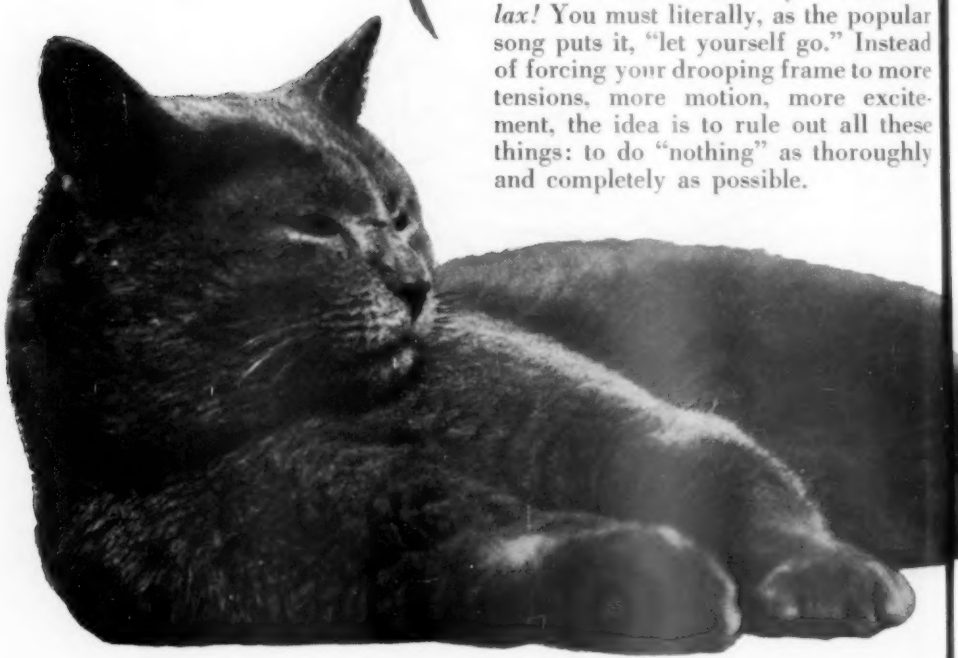
• About a month ago, horrible bumpings and scrapings were heard twice a day at the nurses' residence. This minor earthquake turned out to be Annabelle—doing her exercises. Morning and night she could be observed, twisting herself around on the floor in a series of perfectly terrific gyrations.

"You know—for relaxation," she would gasp, as she folded herself into a new sort of pretzel. "Great way to break down tensions."

Now Annabelle was a busy girl. She worked nine hours a day on a busy surgical ward. Somehow, the "relaxation exercises" didn't work. Instead of putting her into a beautifully limpid state, they helped wear her out still further; at the end of the month she landed in the infirmary, with a full-blown case of influenza and exhaustion.

Annabelle learned the hard way what most R.N.'s find out sooner or later: that strenuous exercise isn't always the way to relax—not when you're in a physically demanding profession.

Exercise has its right and proper place as recreation, as a change of scenery, as a source of sunlight and fresh air. But to relax—you must *relax!* You must literally, as the popular song puts it, "let yourself go." Instead of forcing your drooping frame to more tensions, more motion, more excitement, the idea is to rule out all these things: to do "nothing" as thoroughly and completely as possible.



BY HENRIETTA STREET, R.N.

Feel all fagged out when you go off duty? Take a tip from kitty, a past master in the art of periodic relaxation. . .This article should help all nurses who work under tension. It's recommendations are medically approved and based on scientific research.

Kamp from Black Star

This theory of relaxation has a perfectly scientific medical basis. It was worked out first by the late Dr. Edmund Jacobson in the Laboratory for Clinical Physiology of the University of Chicago. Dr. Jacobson, in his book for professional people, "Progressive Relaxation," proved by a series of brilliant experiments that many of our minor and major ills are the result of a continuous and mounting tension in work and play. He found women with mucous colitis and high blood pressure who were miraculously cured after learning to really relax. From research, he built up a system of relaxation since used by neurologists in their practice, by educators in schools, by employers in industry. The method is easy—and it gets results.

Here's how you start. You plan for a period of complete rest each day, in the middle of the day. You have to *learn* to relax, just as you learned to give a hypo. It takes practice and a little time—and if you're irregular about trying, your results may come slowly. Your rest period can come at any convenient hour. If you're working split hours, an excellent time is just after lunch. If you work straight eight hours, just after 3:30 would be a strategic time. If you work nights, the same program can be arranged to fit your working hours. The ideal plan is to have half an hour or an hour free. But even fifteen or twenty minutes daily will show results.

Insulate your room, as far as possible, against the dormitory noises. Be sure you won't be interrupted by buzzers and friendly neighbors. Fix yourself up as you would the most neurotic of your patients: just the right amount of cool air, muted sunlight, not too many covers. Get a pillow that feels comfortable . . .

. . . And take off *all* your clothes. The old idea of popping off your shoes and lying down for forty winks isn't practical. You may be able to get forty winks, but you won't get real relaxation.

The trick, in learning to relax, is to learn *not* to do things. When you've learned *not* to do enough things, you'll be able to relax at any time, anywhere. You begin by lying flat on your back, your arms a little way from your sides, your legs slightly apart, your eyes closed. Now flex your arm muscle, bend your arm at the elbow. That feeling of flexion, of tenseness, is the feeling you want to eliminate.

After your arm is bent, drop it like a weight upon the bed. Don't put any effort into it—just take all effort away. If you are able to do this, your arm is relaxed. As you practice, you'll be able to relax it more and more thoroughly. In the beginning, you may have a tendency to *put* your arm down, or to move it, once it's down. After a while, you will learn to drop it. That's relaxation.

While you've been relaxing your arm,

other parts of your body may still be tense. Dr. Jacobson proved this by electrical measurements of body muscles. He found, to his own satisfaction, that the body isn't all relaxed at once. You may relax your arms and legs, yet your forehead may be wrinkled with a deep frown. You are not really relaxed until each part of you rests in the same effortless way. Hence you must learn to relax the various parts of your body separately.

Once you've relaxed your arms, start on your legs. Next you can practice on your neck and trunk. Use the same method, "tense" the muscles first to get the idea of what you're *not* to do. (You'll know when a part is relaxed. You lose a sense of location in that part; it rests easily, with a comfortable feeling rather like floating.)

After you've conquered the neck and trunk sections of your anatomy so that your neck is limp as a willow wand and your abdomen sinks comfortably into your backbone, try relaxing your face muscles. It's surprising how you can *think* you're relaxed, and still keep your face tuned up to that intelligent look you use for ward rounds. Relaxation of the mouth muscles may make you look for the time being as if your I.Q. were 40. But later you'll look all the more alert for having tried it.

Needless to say, all these separate relaxations can't be learned at once. Try one part one day, other parts the next. Soon it'll be habit to keep your legs relaxed while you're learning to "let your face go."

Eyes are probably the most difficult part of the body to relax. It takes some people more than a week to master this part of the program. For R.N.'s it's a particularly important phase of the relaxation "cure." Try looking hard at your fingers held several inches from your face. Then bring the fingers close to your nose, feel the "tenseness" and eye strain involved. Then close your eyes. Imagine your eye-balls are falling 'way back in the sockets. Don't look at anything or think about looking at anything. Soon you'll get results. For relief from the sub-marginal eye strain that almost all nurses suffer, this exercise is excellent.

Having learned to relax all these parts of your body, you should be (to all appearances) almost a rag doll during your hours of rest. And you should come bounding back afterwards, invigorated and full of pep for the rest of the day's work or play.

But you're not through yet! You still want to learn how to ease up your mental processes. You may have every square inch of your body in repose, but if your mind continues to speed ahead like a twelve cylinder Lincoln-Zephyr, you are not relaxed—and you're not going to be satisfactorily rested. Psychologists have proved that if you think of giving four bed baths, while you're supposedly relaxing, your arm muscles unconsciously tighten and your leg muscles flex ever so slightly. To make your mind a blank, think first about some high-speed action—a train dashing along a track, or a plane doing a power dive. You'll get a mental picture, a feeling of tenseness behind the eyeballs. Then wipe out the picture as if it were drawn in chalk on a blackboard. It's not easy to do but can be acquired with practice. If you fall asleep in the process—all to the good!

Suppose your hour of rest is over and you dash back to the hospital a new woman. Won't you get tense and tired all over again, with all the work you have to do? Psychologists say not. They say that as you repeat your practice, relaxation gets to be a habit; you carry its benefits over into your ward work and even into your play. Although you're sitting or walking, you are "differentially relaxed." Only the muscles necessary to do the job are working. You aren't, for instance, screwing up your forehead, and tensing your abdomen when you [*Continued on page* 58]

NUTRITION Briefs

● If your doctor, called in to treat you for a gastric complaint, wrote out a prescription which read "Rx—One Apple," what would you do? Call in the next medico

on the list, and put the first down as a practical jokester?

Chances are your first doctor would be guilty only of keeping up with his profession. Nutrition headlines now give credence to the old-fashioned theory that an apple a day, while not exactly giving a leave of absence to the general practitioner, at least aids him in his cures.

The apple growers of the State of Washington have recently sponsored a study which seems to prove this simple fruit an effective item in the prevention of infant intestinal troubles. A prepared apple powder, added to the formula of babies suffering from G.I. upset caused symptoms to disappear within a few days.

In a recent epidemic of infectious diarrhea among infants in a Portland (Ore.) hospital, this treatment was reported used with "very gratifying" results. The author has had similar successes in treating stomach upsets which accompany teething and hot weather.

Older children and adults also reportedly respond to the apple treatment. The fruit powder, cooked with milk, custards or rennet-custards, helped combat attacks of food poisoning and indigestion in grown-ups.

Chemists explain the magic of the common apple as a reaction which inactivates the bacteria causing digestive troubles. The detoxicating agent is reported to be particularly potent in Winesaps and Yellow Newtons. In addition to its medicinal powers, apple is a good source of Vitamins A and C.

Now there's one more good answer to the age-old biblical question: Why did Eve pluck the apple? Adam probably had a stomach-ache!—*Ira A. Manville*: *Apple Therapy. Archives of Pediatrics. May* 1940.

● Ever have that "sinking feeling" in the middle of the morning? Your blood-sugar count was low and you knew it. But what to do?

You needn't be a golfer to benefit by the outcome of recent research in Oakland, California. But it's significant that a high fat diet and candy at the ninth hole pulled golfers' scores down and their spirits up.

Thirty male golfers with adventurous natures consented to be subjects for a course of strenuous experiments. They ate their usual luncheon and played from one green to another in the customary manner, except that they omitted cigarettes and had a blood sugar taken at every other hole. Sugar counts were also taken before and after lunch.

After-meal blood sugar reached its peak at about the fifth hole. At the seventh hole it had dropped back to the level of

the third. From the eleventh to the fifteenth holes, it was well below fasting level, rising slightly at the last two holes.

[*Continued on page* 43]

ECONOMY

• Last month, the ANA borrowed a scalpel and made a neat incision into the association's budget for the remainder of the year.

Among the items sacrificed, in the interest of economy, are: printed reports of the biennial convention; board, committee, and section meetings (except where absolutely essential); special field service (except assignments to which headquarters is already committed); and the centralized program for the newly created men's and general-staff nursing sections.

R.N. is whole-heartedly in favor of elimination of all but essentials when the budget is at stake. But we question the long-range economy of limiting activities of two sections formed last May because they were sorely needed.

At the convention, the men and the general-staff nurses made convincing pleas for establishing sections to represent them in the national organization. Their recommendations went to the ANA board and were accepted, *because the board apparently agreed these two new sections were justified.* Has the picture changed? Do these groups no longer need special consideration?

Men nurses are currently more than ever concerned with formulating a constructive program. We hope budget cuts will not deprive them of adequate ANA guidance.

As for general-staff nurses, authorities agree they may form the bulwark of the nation's health in the defense program. The ANA itself said, in the *American Journal of Nursing* for October, "Gen-

eral-staff nurses provide the backbone of a good nursing service. Some part of the work they have been doing can properly be assigned to subsidiary workers *but there is no substitute for real nursing. . .*"

The troubles of the staff nurse are legion. In many cases, she considers herself underpaid, overworked, inadequately housed. More than that, the work itself offers too few satisfactions to hold nurses in the field or to draw new talent to it.

This is a moot question in times like these. Nursing leaders insist that standards of nursing be maintained—defense or no. But if professional nurses quit general staff posts to assume more interesting assignments under the defense régime, hospital administrators may be forced to employ subsidiary workers to stop up the gaps. It is not enough to suppose that vacancies will be filled by recent graduates of nursing schools. They, too, will want to dodge staff nursing if that work continues to offer little opportunity.

An active ANA section would focus professional thinking on this group, ease some of its problems, and thus make staff nursing generally more attractive.

How much is to be saved, actually, by limiting cooperation with staff nurses to a thin minimum? How much is to be saved, in the end, by scuttling now the support and enthusiasm of thousands of nurses?

We don't believe the majority of nurses want this kind of economy, however well intended. ANA members may well ask if there are not other budget items which might better stand reduction.

Globe

Vanda Summers R.N.

• One night in 1918, when the final chapters of World War I were being written, two women in a harried medical outpost in France paused for a quick meal and a much-needed break in their duties of caring for wounded French and American soldiers. One was a middle-aged American woman, the other an English girl barely in her twenties. Both were nurses, serving in Anne Morgan's American Committee for Devastated France.

As they ate, the older woman talked eagerly. The scene changed from war-torn France to the green hills of Kentucky, where hundreds of mountain families continued to suffer year after year from ignorance and lack of medical and nursing care. The American woman unfolded her dream-project, a plan to establish a nursing service which would bring care and health to these under-privileged people. "I'd like to have you with me, when I get started," she said to the English girl. "I'll be there," answered the English nurse simply. Thirteen years later, she was.

The American woman was Mrs. Mary Breckinridge, member of a prominent Kentucky family. She had devoted her life to nursing, and her goal was the improvement of health conditions among the Kentucky mountaineers. Miss Morgan selected her to head the nursing division of the Committee for Devastated France.

The other nurse was Vanda Summers, a dashing young British girl who had left the ambulance corps of the British Women's Legion to join Mrs. Breckinridge's rehabilitation unit.

The subsequent friendship of these two women reached across thirteen years and three continents. It brought them together again in the materialization of Mrs. Breckinridge's dreamed-of nursing service for the Kentucky hills.

Vanda Summers was born of British parents in a small town in Egypt, somewhere around the turn of the century. Her early life was a kaleidoscope of travels through remote and bizarre points in the East, in company with her parents and two older brothers, for her father was a linguist and translator of the Bible into Arabic and other languages. Vanda studied music at the Royal Academy in London, and then decided on nursing, entering the University College Hospital school of nursing in London. She completed her nursing course and added an extra year in midwifery.

In 1926, Mrs. Breckinridge finally realized her dream. The Frontier Nursing Service was founded, with headquarters in Wendover, Kentucky. For the first time, the Kentucky hill folk were to have regular nursing care and health instruction. Financed principally through philanthropic contributions, the service instituted a hospital in Hyden, Kentucky (the hub of the service), and six outposts deep in the territory which they serve.

By 1930, the Frontier Nursing Service was plainly a permanent institution. In London, where she was continuing her nursing studies and practice, Vanda Summers received Mrs. Breckinridge's invitation to join up. She began immediately to prepare to leave for America.

One of her first moves on entering the United States, was to apply for citizenship. She then went straight to Wendover and reported to the F.N.S. for duty. The outpost to which she was assigned was the Clara Ford Nursing Center, at Red Bird on the Red Bird River, so called because Clara Ford, wife of Edsel Ford, donated it to the service.

Frontier nursing jobs provide a good living, says this young nurse. Her outpost is complete and comfortable in every detail, with living room, dining room, bedrooms, bathroom, and clinic. All her equipment is furnished, except food and maid service. A native girl serves as housekeeper and cook. She has a beautiful thoroughbred bay horse, "Buddy," furnished her by the service. Her salary is $125 per month and she has six weeks off with pay each year.

Although frontier nurses have to work like Trojans to win a place in the mountain area, it is, Miss Summers says, "well worth it!" At the advent of the service, the mountaineers regarded them with distrust, refusing to call a nurse or to abide by health rules. Now each nurse has the admiration and respect of her entire section.

Principal care required is for the large volume of obstetrical cases, averaging one delivery a day. The only doctor in the area is at the medical center in Hyden, and not one in fifty cases can (or will) be moved to the hospital. That leaves the job up to the nurses.

In the beginning, they were opposed by the "grannies," as the hill midwives are called, and by the Holy Roller religious sect. The grannies, whose chief treatments consisted of placing a knife beneath the bed of the

expectant mother "to cut the pain in two," and of spitting in the new-born infant's eyes for luck, resented the competition of the "fotched-on" (meaning brought in, or imported) nurses. The Holy Rollers did not object to the nurses "cotching" (delivering) their babies, but had religious prejudices against using medicine in any form. They would not submit to inoculations or take medicine and, indeed, seemed to have equal prejudice against cleanliness and sanitation. This opposition, however, manifested itself only in passive refusal to have anything to do with the F.N.S.

Nowadays, the frontier nurses have overcome much of this feeling. They are, in fact, frequently called to deliver babies for daughters of the same grannies who formerly had an unhygienic monopoly on the midwifery business.

Chief problems of the frontier nurse are the unwillingness of the mountain folk to leave their homes for medical care, and the difficulty of transportation through the mountain regions. Horseback is the only safe mode of travel. At all times there is danger of being trapped or cut off in the hills by sudden risings of the mountain streams, or by landslides during storms.

While entertaining visitors one morning, Vanda Summers received news that a woman five miles from the outpost had apparently "reached her time." Three rings on the party line from the forest ranger's station brought the word from the woman's husband, who had ridden two miles on a mule to make the call. Heavy rains during the previous few days had swollen the streams. The water was above the low-

1. *When an urgent call comes through, Vanda Summers saddles Buddy, puts up her saddlebags and, carrying a poncho, sets off on the wilderness trail.*

2. *Floods make the river too perilous for Buddy to swim. A flat-bottom boat ferries the nurse across.*

3. *On the other side, a borrowed horse waits to take Miss Summers up mountain trails and through thick forests. Her destination is the shack* (below) *of a typical mountaineer's family. Here she must struggle with superstition and limited equipment. But she never fails in her determination to provide expert nursing care.*

Photos from Globe

water ford, with the flow too swift to risk swimming Buddy across.

Neighbors were called into consultation. A boat was produced to get Miss Summers across the river. On the other side a borrowed horse was waiting. From there, the call led through several creeks and branches, up mountain trails and through thick forests. Finally they arrived.

At first glance, it was apparent that all wasn't going well with the expectant mother. Since this was her ninth child, labor should have been progressing normally. Examination convinced the nurse that her patient should be moved to the hospital, but the woman obdurately refused. After a four-hour vigil, Miss Summers returned to Red Bird to consult the doctor. He ordered that the patient be brought to the hospital and his instructions were relayed to the husband by the "fire-line" telephone. Time passed—but the patient did not arrive. Soon the river had subsided somewhat, so Miss Summers saddled Buddy and started back to see what was wrong. Arriving at the branch on which the family lived, she found them heatedly arguing about how to transport the woman down the side of the creek to Arnett's Fork.

Miss Summers finished the argument by placing the woman in a home-made cane-bottom chair, and making two of the men carry her in this improvised litter down the middle of the branch to its intersection with the river. Here they were met by a neighbor in his [*Continued on page* 56]

COLLECTORS' CORNER

Hobbyists! Here's a spot all your own. If you want to add to your collections, trade with other nurses, or discuss mutual problems, address the HOBBY EDITOR. *Items should be short, to permit inclusion of as many as possible each month.*

* * *

RING-BELLS. My new hobby is collecting bells of all types. I'd like one from each State and as many foreign countries as possible. I'm hoping you other nurses will help me out. All contributions will be acknowledged and postage paid. Amy M. Sundquist, Box 828, Rawlins, Wyo.

STAMPS. My hobby is collecting old and new stamps from the United States and foreign countries. All contributions will be greatly appreciated and acknowledged. Iva Baltes, 420 E. Overland Drive, Scottsbluff, Nebr.

BUTTON-BUTTON. I collect buttons and would like to hear from collectors in other States. Would be happy to receive any kind of buttons, but especially antiques. Will return postage to all senders. (Mrs.) Maybelle McLemore, 1514 S. Elm St., Hope, Ariz.

ODDITIES. Will you all help me start a collection of unusual items about nurses in the news? Clippings of published material are preferable. But original accounts will be accepted, if accompanied by proof of authenticity. I'll refund postage and acknowledge all contributions. Roberta, care of Hobby Editor, R.N.—A JOURNAL FOR NURSES, Rutherford, N.J.

TOYS. I make many designs of stuffed dolls and animals and will sell or trade for anything you have of equal value. Matilda Braun, Route 2, Higbee, Mo.

POSTMARKS. Most people collect stamps, but I prefer postmarks with stamps attached. If R.N. readers will send me some from out-of-the-way or well-known places, I'll mail them something for their hobby. Just enclose a note telling me what way I may help. B. Chapman-Smith, 27 Maple Ave., Keyser, W.Va.

IT COMES IN *Cans!*

BY HELEN MORGAN

Last month Miss Morgan gave you the inside story of canned foods. This second piece suggests unusual ways in which they may be prepared.

• Not so long ago, it was hard to imagine a dinner of ham, sweet potatoes, vegetables, baked apples—all out of cans—and gingerbread and muffins made from mixes packed in tins. But today practically anything comes in a can or a container. The problem no longer is availability of foods all the year 'round, but what to choose from the tremendous variety available—and how to best use the canned food you've selected.

In making selections, it's wise to consider the use of the product. Read the labels, which will tell you whether the syrup is heavy or light. "Fancy" quality has the heaviest syrup, consisting of ¾ to 2¾ cups of sugar to one cup of water. There is a ten to fifteen per cent reduction in the quantity of sugar used in U.S. grades "Choice," "Extra Standard," and "Standard." Choose a thin syrup for breakfast when tartness is desired. Don't buy Fancy creamed corn for soup.

Remember that pineapple comes in several styles. Pineapple circles are best for salads, desserts; small circles for broiled meats; vertical cuts may be placed in a glass, Hawaiian style, with a chilled drink, or served as an appetizer with a wedge of lime. Crushed is for sundaes and sauces. (Melt marshmallows in the juice of crushed pineapple, add some of the fruit, and you have a nice sauce for ice cream or puddings.) Tidbits are for fruit cups and frozen salads.

Although expert chefs prepare the food that comes in cans, few cooks can resist adding their own ideas. New uses for canned products are consequently always cropping up. Most versatile are soups. These are usually spiced and must, therefore, be used sparingly or not at all for patients. (There is a chicken broth for invalids.) For your own enjoyment, however, we can't resist sneaking in these quick-to-get and delightful dishes.

The joys of canned creamed mushroom soup are almost endless. Mix it with chopped turkey, or with a can of tunafish. To the tuna add a few green peppers, stuffed olives, both chopped. Pop it on the stove and there! It's done! For something more elaborate, add some biscuit dough (made from prepared biscuit flour), cover the tunafish mixture and brown. Now you have a pie. Onions or cheese may be added to this dish.

Cream of tomato soup is another standby. Mix it with a bouillon cube and a little flour, heat, and use as a sauce for meat loaf.

For something really hot, mix a can of tamales (this is an old California custom) with a can of whole kernel corn, chop up some black olives, and heat. Or purée some canned chili con carne and add the sauce to your pot roast. [*Continued on page* 52]

Sherman SAID A MOUTHFUL!

BY ROXANN

• You don't have to have a box seat at a bombing to get a load of this war, as I'm finding out daily. Until this world-wide slugging match came along, life for me involved only such run-of-the-mill headaches as flighty interns, persnickety patients, labor unions, and student nurses with ultra-democratic ideas.

Those were the days when nurses relaxed and laughed after dark. Now things are different. A nurse will drag out her needles and yarn and knit-two and drop-three while she tells you all about the patient in 314. Shop talk these days sounds like a song with castanet accompaniment, and an obligato of muttered "Fourteen rows . . . sixty stitches . . . knit one, purl one . . ." At conferences I am faced with rows of downcast eyes—not modesty or shame, just attention focused on the socks and afghans and sweaters growing on their laps.

Don't think I'm not in sympathy with the cause!! I am. But I held out as long as possible on the handwork angle. I figured the soldiers and civilians over there had enough to contend with, without my adding to their burdens. But the other nurses' nimble fingers and scornful comments on my yarnless lap finally wore me down, and I went over to the branch office and got some wool for a sweater.

Since no one was ever more gifted with thumbs than I am when it comes to needlework, I decided to have a practice session in my own room before I made my first public appearance with knitting bag and needles. It was a smart move. By the time I had finished casting-on the required number of stitches, I was a fit subject for a plaster cast myself.

Stoically, I started to knit. Most of the girls, I remembered, had sort of sneaked the yarn over the needle, with an almost imperceptible movement. Not I! I do things with a flourish. I jabbed the right needle through the first stitch, tossed the yarn over it, and described a semi-circle with both needles, like a man rowing a boat . . . I managed to finish two rows before I bit my tongue badly—I've never been able to cure myself of my childhood habit of parking my tongue between my teeth when I'm concentrating on the job in hand. Anyway, I learned during my practice session to manage my needles without being a public menace. And was I proud!

But not for long. As the sweater grew, it became evident even to my own indulgent eyes that it was a mite on the large side. I kept doggedly on, however, until Mildred Evans said brutally, "Who are you making it for—Man

Mountain Dean? Or twins? You must have doubled the recipe!"

"Let her alone," ordered Margaret. "You're as bad as my mother-in-law. I get the toe of this sock done, and she says, 'That can't be right, even if the directions say to do it that way. *I* never knitted socks that way, and I've been knitting all my life. Here, let me rip it out and do it *right*.' And this," Margaret concluded grimly, holding up the foot of a sock, "is the result of three weeks' work."

Well, I finished the sweater eventually. It should make a nice pup tent for a couple of British soldiers.

It seems that I'm not the only one that is bungling for Britain. I took a look-in at the Red Cross headquarters the other day to lend a hand with the bandage-rolling. I've always had a yen for the good old days before central-supply rooms when, as student nurses, we did a spell of duty making gauze sponges, cotton balls, tampons, and such. I recalled the hours spent snipping, cutting, folding—all quite automatic after the first few tries—while your alleged mind was free to wander in less prosaic fields. In other words, when I hopped over to the workroom I was secretly hoping to recapture a moon-session.

Moon session, my ectoplasm! The place was about as conducive to private reflection as a car barn. The town-and-country girls were going after the supply-room chores with the enthusiasm of a steeplechase. Sturdy brawn developed on the golf links was not averse to hoisting a bolt of muslin onto a work table. While boxes were emptied and filled and white gauze flowed like milk, they never dropped a syllable. Some hospital lost a swell head nurse when the gal in charge of the outfit took up Society and Service. She handled her butterfly battalion like a master. They

"She handled her butterfly battalion like a major. They worked and liked it . . ."

worked and liked it.

Of course, the war fever has spread to the patients at the hospital. They are sewing and knitting and whittling like mad, and that's fine for them and for the refugees—and for us.

I'll admit we had a little trouble with the psychopathic old lady in 3B who got the idea she was Joan of Arc and yelled for two days and nights for tonsil wire so that she could knit herself a coat of mail. And there was the old gentleman whom the O.T. worker taught to crochet mittens, only to find that he had woven his long grey beard firmly in with the wool.

The climax—perhaps I should say the millenium—came when Dr. E. T. Jones (the one we always refer to as the Saber-Toothed Surgeon) stamped into the O.R. early as usual for a scheduled laparotomy, and instead of threatening to smash the sky light or chop the scrub nurse to bits he climbed up on a stool, pulled a neat hunk of yarn and needles out of his pocket, and calmly picked up where he had left off.

But one of our best headaches is the radio situation. Not so long ago a patient would twiddle a knob and come up with a nice swing band, or Kate Smith, or Amos 'n Andy. Now they wake up at dawn to hear the first commentator and lie there listening until the last one signs off at night. Then they stay awake for a couple of hours to catch up with their worrying. When they *do* go to sleep, they dream Grade-A nightmares, with bombs bursting in air and submarines sailing up the avenue.

The need for aspirin, hot milk, back rubs, and [*Continued on page* 40]

My story

"NO THANKS EXPECTED"

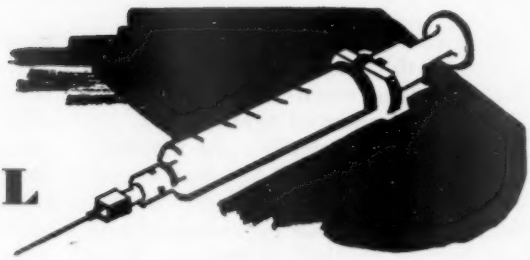
● This story is brief and without much glamor. But it does bring out a point—that an R.N. should be satisfied with results and not look for thanks in the bargain.

The scene was the county fair in Ellenville, New York, which draws crowds of people from far and near. There were exhibits of all kinds—farm implements, livestock, canned fruits and vegetables, and fancy articles made by the farmers' wives.

Standing near me, watching an exceptionally fine cow being judged, stood a woman with a small child in her arms. She was more interested in the cow than in the baby who was devouring a large cracker. I heard a blobbing sound and turned to see the child getting black in the face. The mother had the look of a woman who might have been holding someone else's infant.

Without waiting for a by-your-leave, I grabbed the babe from his mother's arms and turned him so that there was little dignity in his position. I slapped him several times from the top of his smooth head to his turned-in heels. By that time we were surrounded by people who were looking for results.

My heart was pounding in rhumba rhythm when out popped the lump of cracker and the child set up a healthy wail. I turned him right-side up and handed him back to his mother. She looked completely blank and quickly disappeared in the crowd, much to the amusement of my friends. Their only comment was, "That's what you get for being an R.N.!"—HENRIETTA W. SCHWAB, R.N.



METRAZOL SHOCK

BY ALLEN KLEIN, PHAR. D.

• Rapid strides are being made in the clinical investigation of the drug metrazol as a therapeutic agent in various mental disorders.

Convulsive shock and the profound changes it causes in the human organism, as produced by metrazol, has been reported of value in the treatment of schizophrenia (dementia praecox), depressive psychoses, manic depressive psychoses, depressive reactions at the menopause, involutional melancholia, and mild depression. [R.N., November 1938.] By the end of 1939, over 500 articles had appeared on the subject in the medical press of America with many other reports coming from abroad.

Metrazol is the council-accepted* name for the chemical, *pentamethylentetrazol,* known in Europe as cardiazol. Metrazol is a white, crystalline, faintly bitter powder. Oddly enough, small amounts are practically odorless, but in large quantities a characteristic odor is noticeable. The chemical dissolves readily in water, alcohol, and most organic solvents, forming neutral solutions. It is extremely stable and cannot be broken down or changed except by vigorous chemical procedure. For a number of years metrazol has gained recognition as a useful analeptic, combating respiratory and circulatory failure in infantile asphyxia, pneumonia collapse, carbon monoxide poisoning, etc.

First report in the United States on convulsive therapy with metrazol came from Friedman in 1937, about two years after the original foreign report by L. Meduna. Other promising preliminary studies sharpened interest and brought hope that immediate improvement or remission of early cases of dementia praecox would result.

A greater percentage of complete remissions appears to occur in early acute schizophrenia, particularly the stuporous catatonic individual. A good average of improvement and remission in the paranoid types has been reported by Finkelman and others. This investigator states that the rate of remission is almost inversely proportional to the duration of the psychosis. He claims that when the psychosis has endured for over three years possibility of remission is slight. The literature cites 67 to 85 per cent of full remission or great improvement after metrazol treatment in cases where the disease was of less than six month's duration. The longer the ailment has existed and the more severe it is, the lower is the percentage of success.

A late paper by Bennett gives hopeful results in a series of sixty-one depressive and nine manic cases given metrazol shock therapy. "Of sixty-one depressed patients," says Bennett, "twenty-eight have obtained a full re-

*American Medical Association, Council on Pharmacy.

mission lasting from three to eighteen months; thirty-two obtained a social recovery; but seven relapsed. Four of these were improved again with a second course of treatment; one remained unimproved, and one committed suicide. Fifty-seven of the sixty-one patients obtained rapid improvement with termination of the depression. . .Four of nine manic states obtained a social remission, but two relapsed, one recovering subsequently. . ."

In administration of metrazol there is apparently no relationship between body weight and the quantity of drug needed to produce convulsive reaction. The dose appears to be the smallest amount necessary which, upon intravenous injection, will produce a typical convulsive seizure. Finkelman advocates a first dose ranging from 2 to 5 c.c. of the 10 per cent solution; about 1 c.c. for each 30 pounds of body weight but not over 5 c.c. for the initial dose.

Upon determination of the convulsive dose, the same quantity can be used for subsequent treatments until no reaction is produced. Dosage is gradually increased when necessary. Treatments are usually given two to three times a week. In schizophrenia, twenty to thirty injections are administered in most cases before therapy is considered complete. Six to eight shocks usually bring about recovery in manic-depressive psychoses.

What happens when metrazol is thus injected intravenously?

Within five seconds a whole train of body movements are set off. First there is a cough or breathing cry, uneasy rolling of the head and blinking, followed soon after by intense flushing of face and neck. Seconds later, comes the stage which brings mild clonic convulsive movements of face, shoulders and arms. Half a minute later the tonic phase is introduced by a yawn. Insertion of a mouth gag at this point will prevent injury to lips or tongue. The head is retracted and the back arched. Wrists and legs are contracted in extension and the extremities often assume different postures. A subsequent clonic stage begins in the fingers. Soon the entire body becomes involved, with rapid movements becoming less frequent and ceasing in about twenty-five seconds. Simultaneous with the tonic phase, apnoea begins and persists until completion of the final clonic phase. A progressive increase in cyanosis gradually fades as the patient resumes normal breathing. The whole seizure lasts about sixty to seventy seconds. Patients may then fall asleep for periods of minutes to hours.

A number of complications arise with metrazol-induced convulsive shock. Bennett considers these more hazardous than hypoglycemic shock. He mentions the difficulties as cause to restrict the use of metrazol in serious psychotic states to experienced hands in psychiatric hospitals. Spinal and leg fractures occur in a relatively high percentage of cases. The nurse or physician must ward off damage to the tongue. The usual precautions must be taken against dislocation or fracture of the jaw, arms and other body parts. Nausea and vomiting are not infrequent during treatment. "Lung abscesses" have been reported. Other untoward effects are often present. Spinal anesthesia has been used [*Continued on page* 44]

● DID YOU KNOW THAT—nurses at St. Mary's Hospital, San Francisco, eliminate the spread of impetigo among infants by using an iodine solution as a germicide? The technique is to dip their scrubbed hands for 10 seconds in a solution of one per cent iodine and 1.5 per cent potassium iodide, rinsing with thiosulphate solution for 5 seconds. Solutions are changed every six hours and the cost is about 14.5 cents per liter. The effectiveness of iodine in this respect was uncovered as the result of extensive research by bacteriologists. According to Welch and Hunter, of the U.S. Food and Drug Administration, iodine not only kills bacteria but aids the phagocytes in their work of engulfing invading organisms.

IN REVIEW

A QUICK GUIDE TO CURRENT BOOKS OF INTEREST TO NURSES

PHYSIOLOGY AND ANATOMY.

Esther M. Greisheimer, M.D. $3.50. *J. B. Lippincott Co. (Fourth edition.)*

● The author of this text believes in the graphic method of teaching, uses 474 illustrations and diagrams (many colored), and packs her 789 pages full of anatomical and physiological detail. While some instructors may regard this text as too minutely factual for classroom use, its value as a reference cannot be questioned. In the teaching edition, tinted inserts point up the highlights of each section.

Dr. Greisheimer presents the anatomy of a system first, then the physiology, for —as she says in her preface—"the study of structure is essential to an understanding of the function." At the end of each chapter she includes a group of practical considerations based on the text. These illustrate theory by presenting case examples.

ESSENTIALS OF MEDICINE.

Charles P. Emerson, Jr., M.D., *and Jane E. Taylor,* R.N. $3.00. *J. B. Lippincott Co. (Fourteenth edition.)*

● Dr. Emerson is perhaps one of the best-known authorities on medicine for nurses. For he has been revising and improving this text for thirty-two years. This year he has a new collaborator who brings to the current volume the benefit of her association with the Yale University School of Nursing.

This is a learned discourse, comprehensive, and meticulous in its attention to details. To this reviewer, at least, it might be improved by a less verbose style and by a more simplified typographical make-up. Headings appear in light-face type, sub-headings in bold-face; the result is confusion in the mind of the reader as to the relative importance of the topics thus singled out. In a book crammed full of

authoritative medical information, it seems too bad not to guide the reader to the facts he wants in a direct fashion.

Chief feature of the new edition is the expansion of sections on specific nursing care, including such new topics as skin diseases, endocrine ailments, and allergic conditions. This emphasis on nursing care is a welcome addition. It is to be hoped that the publisher will encourage Miss Taylor to go even further when the next revised edition is under consideration.

GETTING READY TO BE A MOTHER.

Carolyn Van Blarcom. Revised by Hazel Corbin, R.N. $2.50. *The Macmillan Co.* (*Fourth edition.*)

● Ever since 1922, this layman's text on pre-natal and baby care has delighted mothers and helped nurses. Now it appears with added attractions—a chart for recording baby's progress, a series of new photographs of fetal growth and childbirth processes, and new medical facts on child care.

If you recommend this book to your friends, warn them in advance that it was written for the *average* mother and may be too simplified for their needs. But although it is simple, it is accurate and complete.

NURSES' HANDBOOK OF OBSTETRICS.

Louise Zabriskie, R.N. $3.00. *J. B. Lippincott Co.* (*Sixth edition.*)

● In the ten years since the first edition of her book, Miss Zabriskie has observed vast changes in professional attitudes toward obstetrics. "Childbirth," she says in her preface, "is no longer a matter to be awaited helplessly by the expectant mother with what fortitude she is able to muster . . . It is, instead, the climax of a true state of preparedness."

Nursing's responsibility in this particular preparedness program is adequately defined by the author. Her book is intended primarily for students, but it should serve as a thorough refresher for graduates in private practice and public health. The new edition brings pre-natal and post-natal techniques up-to-date in clear, easy-to-read fashion. It also contains several chapters contributed by outstanding physicians. These latter sections cover new methods for diagnosis of pregnancy, recent endocrine discoveries, latest vitamin facts, and a history of obstetrics. Appended is a pronouncing glossary of obstetrical terms. This volume continues to set the pace for texts in the obstetrics field.

INTRODUCTION TO MEDICINE.

Don C. Sutton, M.D. $3.25. *C. V. Mosby Co.*

● Dr. Sutton undoubtedly knows nurses. He has managed to present, for their use, the highlights of medical diagnosis and treatment without wallowing in excess detail or controversy.

Although this book is directed toward R.N.'s and students, nursing care is not emphasized. Such nursing techniques as are included are mostly in the form of illustrations (borrowed from Tracy's "Nursing, an Art and a Science"). The first few chapters on social service and the mental reaction of the patient to disease, might seem better suited to a nursing arts text. Otherwise, Dr. Sutton has written an extremely useful book. For classroom purposes, it conforms to the N.L.N.E. Curriculum Guide.

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IONE HILL (or ELIAS): What's happened to you? I'm very much interested in hearing from you. So please write me if you see this. Ethel Rubin, 900 Honor Heights Dr., Muskogee, Okla.

WOMEN'S HOMEOPATHIC HOSPITAL GRADUATES: (Philadelphia.) We are planning a reunion to take place this month. Won't you all get in touch with me so that our list may be brought up-to-date? Marion S. Knoelke, 5850 Henry Ave., Philadelphia, Pa.

BERWICK HOSPITAL GRADUATES: (Berwick, Pa.) We are planning a reunion of graduates after completion of a new addition to the hospital. We'd like to have information about all graduates since the first hospital was organized. Won't you write, please? Esther R. Jones, 546 W. Front St., Berwick, Pa.

ALL NURSES: In May 1924 a private nurse was with a mental patient in St. Petersburg, Florida, accompanying the patient to Ohio. The patient died recently, leaving an estate. Now the executors of the estate are seeking that nurse whose name, apparently, was not recorded at the time. If she reads this notice, will she please communicate with me? (Mrs.) Adla G. Still, 111-22 118 St., Ozone Park, N.Y.

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located now? We were east last year for five months and this Summer I made a trip to Kentucky. Did you know we moved to the east San Diego district? Please write! Ethel P. Madison, 4474 Polk Ave., San Diego, Calif.

KATHERINE O'HALLIGAN: Sorry, but I have lost your address. Have been trying to find you for the past year. Where in the world are you? Won't you write me soon? Josephine F. Siligato, 244 E. 21 St., New York, N.Y.

ALL NURSES: Harbinger House, New York publisher, is planning to issue an anthology of poetry by nurses. Any nurse living in the United States or Canada may submit entries. Poetry may be in any form or length; it must be typewritten on one side of the paper. Return postage should accompany the manuscript. Address: RN-Editor, Nurses' Anthology, Harbinger House, 245 W. 72 St., New York, N.Y.

THEOLA BLODGETT: I have lost your address and would like very much to get in touch with you. This is important. Won't you please write? Margaret Bayles, G. N. Wilcox Memorial Hospital, Lihue, Kauai, Hawaii.

HELEN A. SIKORSKI: (Englewood Hospital, Englewood, N.J.) Will anyone having information as to the present location of Miss Sikorski please write me? Mary Jo Anastasi, 315 La Salle Ave., Hasbrouck Heights, N.J.

HELEN STRADER: (Formerly at Palo Alto General.) A mutual friend has asked me to try to locate you. Please write to (Mrs.) Pauline Goucher, Veterans' Home Hospital, Napa County, Calif.

Sherman said . . .

[*Continued from page* 32]

pillow fluffing became so great that something had to be done about the radio question. Even the patients themselves realized that they weren't getting as much rest as they should. Most of them voluntarily agreed to quiet peri-

M. Burneice Larson, *Director*

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ods during the day and blackouts of the radios at 9 P.M. So *that* problem was solved.

But there were others. The draft bill caused my incoming mail basket to be filled with notes from female members of the staff: "I am resigning to get married." And from such unexpected sources! There was one from flat-footed Hilda, a kitchen maid who had been a fixture of the hospital for nearly twenty years. And one from Miss Jones, who had no chin and hair the color of fresh mud. Maybe D. Cupid won't seriously interfere with conscription, but he put us on the spot for a while.

We've been hit down in the volunteer belt, too. We used to count on the volunteers to man the patients' library, act as hostesses, and fill in a thousand other places, but they're so busy with caring for refugee children, Red Cross work, relief committees and what-not that they figure we can get along without them. We can't complain, of course,

when they're giving so generously of their time to such good causes, but we miss them—and so do the patients.

In other words, I wish that good old, plain-spoken General Sherman were within speaking distance. I'd like to walk up to him and say, "Boy, you said a mouthful!"

Nutrition briefs

[*Continued from page* 21]

At the time when blood sugars were lowest, golfers complained of fatigue, began to make poor scores and lose their tempers. The more composed of the players did not have such marked deficiencies in their sugar counts. Those who ate candy at the seventh or ninth hole had an enviable amount of drive and good humor.

A morning of general duty is quite as strenuous as any eighteen holes of golf. So here's an added argument for that mid-morning snack.—*Michael, Paul: Jour. Amer. Med. Assoc., July 1940.*

Metrazol shock

[*Continued from page* 34]

prior to metrazol administration to minimize the dangers of vertebral complications.

Recently Bennett has introduced a preliminary injection of curare (Indian arrow poison) prior to metrazol. This drug produces a transient motor paresis and thus softens the metrazol convulsion so as to prevent all traumatic complications. The curare-metrazol treatment has proved to be a perfectly safe procedure.

Some clinicians have deemed it well to use artificial respiration during the period of acute apnoea. Injection of a short-acting barbiturate can be employed to interrupt a metrazol seizure where necessary.

Contraindications to convulsive therapy with metrazol include cardiovascular disease, menstruation, acute febrile conditions, blood or urinary abnormalities, malnutrition with avitaminosis or calcium deficiency and resulting bone pathology, record of head trauma with subsequent unconsciousness.

On the whole, metrazol treatment does not seem to change the electrocardiograph pattern from the original. Increase in pulse, blood pressure, and respiration appear temporary. Bennett, who has done quite a bit of work with the chemical, believes that the good therapeutic effects occur from the organic changes produced by the confusional state induced by the convulsion.

Metrazol therapy has been combined with insulin shock treatment. Preliminary courses of camphor have been used by some, and alkalinization with sodium bicarbonate by others. Certain it is that a great number of patients who did not respond to other forms of treatment have partially or wholly recovered after metrazol administration. Only time and further studies will fully evaluate the benefits of metrazol application in mental disorders. The future will answer the questions as to the immediate or delayed effects on the central nervous system, the quality of improvement and length of remission.

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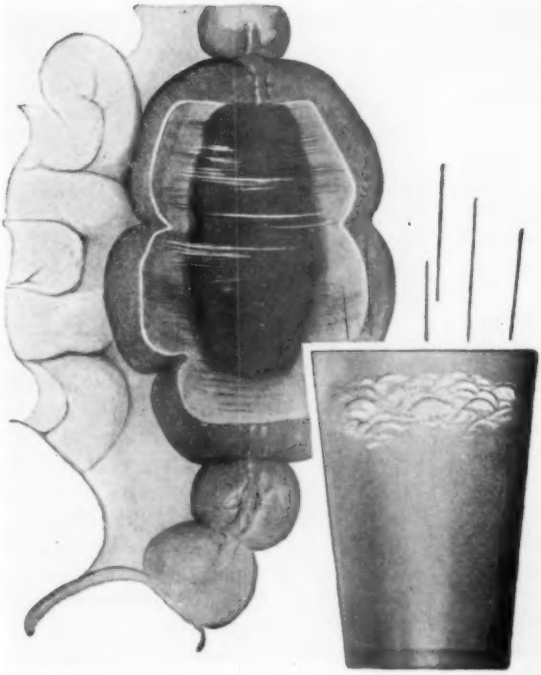

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Gonorrhea in female

[*Continued from page* 14]

Difference of opinion exists concerning gonorrheal infection of the endometrium. Many gynecologists assert that the endometrium possesses a peculiar resistance to the gonococcus and that the organism can traverse the uterine cavity without actually setting up an infection.

Acute gonorrheal salpingitis is one of the most crippling features of the infection. In a large percentage of cases it seals the fallopian tubes, producing sterility. In many others, after the acute process has subsided, abscess or cyst formation, adhesions, or menstrual disturbances may necessitate surgical removal of the uterus or tubes which in itself produces sterility.

It is believed that sexual excess, alcoholic excess, or abortion, in addition to menstruation, predisposes to acute salpingitis. Nausea, vomiting, chill, malaise, fever up to 104° F., rapid pulse, and lower abdominal pain usher in salpingitis. The lower abdomen is rigid and tender; defecation is painful. The patient is obviously acutely ill from the overwhelming infection. The involvement is actually an acute peritonitis of the pelvis, since the pus of the fallopian tubes "spills over" into the pelvis, causing a generalized lower abdominal inflammation.

With judicious management gonorrheal pelvic peritonitis is rarely fatal. Conservative treatment confines the process to the pelvis. The infection runs its course in several days or weeks, then enters the chronic stage. During the acute period, confusion with acute appendicitis is possible. The differentiation must be made with accuracy because surgical intervention before the chronic stage is well developed may lead to extension of the infection.

Hence the prognosis as to life is good, but the outlook as to sequelae is not so

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hopeful. Hydrosalpinx, sterility, dysmenorrhea, metrorrhagia, dyspareunia, pelvic pain, mild lower intestinal obstruction, and general poor health are some of the consequences of gonorrheal salpingitis.

The presence of gonorrhea makes liable the development of extragenital complications. Infection of the eyes, anus, and rectum are possible, and are avoided by properly instructing the patient in hygienic habits. Gonorrheal arthritis is prone to occur; gonorrheal endocarditis is a rare but usually fatal complication.

Gonorrheal vulvovaginitis of children.—The vagina of children and young girls is lined with a thin, infantile type of mucous membrane unlike the cornified epithelium of adults, and is susceptible to invasion by the gonococcus. The infection occurs easily, and is transmitted by contact with contaminated towels, sheets, thermometers, bedpans, and improperly washed hands. The threat of an outbreak of gonorrheal vulvovaginitis always exists in pediatric wards, and children should be examined before admission, to keep out carriers. Nurses and attendants should be carefully instructed as to the prevalence and ready transmissibility of vulvovaginitis, and extreme precautions should be taken to prevent an outbreak. Complications occur infrequently, and consist of urethritis, cervicitis, adhesions between the walls of the vagina, arthritis, ophthalmia, and peritonitis.

Gonorrhea and pregnancy.—The presence of gonorrhea during the parturient state is of danger to both mother and child. Gonorrhea, strangely, does not appear to exert a harmful influence upon the course of pregnancy. However, pregnancy may aggravate a preexisting gonorrheal infection, and may predispose to extension of the process into the uterus and tubes. Gonorrhea only infrequently is responsible for abortion, even though tubal involvement develops.

Experience has shown that gonorrhea of the parturient should be actively treated as soon as discovered. Such treatment may eradicate the infection entirely before delivery or reduce its severity sufficiently to enable mother

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and child to escape complications.

Special precautions are adopted at the time of delivery to prevent sequelae. Manipulation is reduced to a minimum and antiseptics are introduced freely into the vagina. As soon as the head is born, a drop of 1 per cent silver nitrate solution is instilled into each eye. Gonorrhea increases the likelihood of puerperal sepsis.

Diagnosis.—The diagnosis of gonorrhea depends upon the typical findings and the identification of the gonococcus in the discharge. Smears are taken from the urethra, cervix, and the pus from Bartholin's and Skene's glands. A smear obtained from the vaginal vault is worthless. The presence of the typical gram-negative diplococcus within a leukocyte is considered diagnostic. Because the vaginal secretions abound with many micro-organisms, the patient is instructed not to urinate or to use a douche immediately before the examination. Repeated smears may be required.

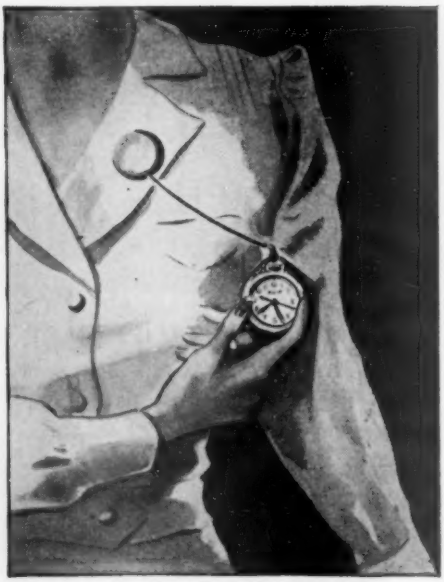
In recent years the technique for culturing the gonococcus has been greatly improved. Many cases of gonorrhea are found by cultural methods that would be missed by smear examination alone. This method is also of great value in determining whether the patient is cured. Secretions are placed on a medium upon which the organisms multiply until there are a sufficient number to identify. Care must be taken to place the specimen in an incubator immediately after it is taken. Even a short wait at room temperature will reduce the number of positive results.

Treatment.—The advent of sulfanilamide and related chemotherapeutic drugs has markedly changed the therapeutic outlook of gonorrhea. The drug has been found to produce cures in all stages of the infection; it is given to pregnant women and to children with vulvovaginitis. In salpingitis, the inflammation subsides and pelvic masses disappear.

General measures are as important as previously. Copious amounts of water, abstinence from sexual relations and alcoholic beverages, a bland nutritious diet, and avoidance of fatigue are essential. Local medication is not necessary with sulfanilamide therapy, although antiseptic douches may be taken for removal of the purulent discharge. The advantage of sulfanilamide lies in its ability to seek out hidden foci of organisms heretofore inaccessible to locally applied surface antiseptics.

Surgical intervention is necessary for the removal of Bartholin's cysts or of pelvic masses if the latter resist chemotherapy. However, operation is not performed for at least six months after the acute infection. Cervicitis, persisting after the eradication of gonococci and giving rise to a leukorrheal discharge, is treated by electrocoagulation or the actual cautery.

Administration of estrogenic hormones is employed in the treatment of vulvovaginitis of children. This sub-



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stance transforms the vaginal mucosa to the adult type which is more resistant to the gonococcus.

[*For a bibliography of the procedures discussed in this article, send a stamped addressed envelope.*—THE EDITORS]

It comes in cans

[*Continued from page* 29]

Of course, such gastronomic adventures are hardly to be recommended for anyone with a sensitive stomach. We just thought we'd tell you!

Here are suggestions for more proper dishes.

How about canned asparagus with cheese sauce, served on corn bread . . . Try canned whole red beets with small white onions. Gives the onions a nice flavor and a lovely blush . . . Use fruit juices in cooking meats. The juice of red plums, for example, poured over a slice of broiled ham. Or crushed pineapple, with some of the juice, mixed with chopped ham and served as a casserole dish . . . Bake potatoes, mash with a little pineapple juice, and serve in the potato shells. Baked potato can be mashed with canned salmon, too, folded back into the shells, topped with a little cheese, and browned . . . Canned puréed vegetables are fine for babies and convalescents.

Fruit juices enhance salads and desserts, too. Here is a recipe, borrowed from Mexico, for a delicate and different dessert. It's called Pineapple Sabayan, and these proportions yield one serving:

1 egg yolk
1 tablespoon sugar
¼ cup pineapple juice (canned)
½ teaspoon lemon juice
¼ teaspoon vanilla
few drops sherry
pinch of salt

Beat yolk till thick and lemony, add sugar and cook over hot water, beating

As prescribed by physicians

BiSoDoL *helps relieve*

Gastric hyperacidity and digestive upsets due to excess stomach acid. Also available—BiSoDoL Mints, in convenient tablet form. Samples free to the nursing profession on request.

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R.N. KEY TAGS!

● For Christmas, why don't you send your friends one of R.N.'s smart and practical key tags? The tag was designed by R.N.'s editors as a service to readers of the magazine. It is attractively embossed on silver-finish metal—and with its goes a unique insurance plan to protect your keys from permanent loss.

Here's how the insurance plan works: On the reverse side of the tag is your personal identification number. If your keys are lost, the finder is instructed to return them to your number which is on file in R.N.'s offices in Rutherford. Lost keys sent to R.N. will be forwarded immediately to the owner without cost.

Hundreds of nurses have bought these tags already. The supply is limited so order now. They cost only a quarter—and you may order as many as you wish. Use the attached coupon when ordering.

Key Insurance Editor
R.N.—A JOURNAL FOR NURSES
Rutherford, N.J.

Please send me_____key tags at 25c each, for which I enclose $_____

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constantly with eggbeater till foamy. Add canned pineapple juice, salt, and vanilla. Remove beater and stir for two minutes longer. Keep hot water below boiling point or mixture will curdle.

Gelatin salads can be infinitely varied by combining various flavors of fruit juices or canned fruits, such as lime and pineapple, lemon, or puréed prunes, and serving with cream cheese. Canned salmon and canned chicken can be added to these salads if a heartier meal is desired.

For the holiday menu, don't forget canned cranberry sauce or jellied cranberries. Try your hubbard squash this year mashed and mixed with a little canned crushed pineapple, then baked. For dessert, mix the juice from canned black cherries with a little cornstarch; heat, add a few drops of brandy, and serve as a sauce for ice cream or pudding. And the patient who may have a little canned plum pudding will be even more thrilled if it is topped

with a mound of eggnog ice cream.

These are just a few suggestions to illustrate the many attractive ways canned foods may be used. And, thanks to the ingenuity of canners and rigid Government standards, you may be confident that when you serve canned foods to your patients you are serving safe foods, foods rich in vitamins and minerals.

Vanda Summers, R.N.

[*Continued from page* 28]

venerable Model T Ford. While it jolted on down the mountain side, Miss Summers rode ahead to telephone for a better car to meet them at the ranger station. A few hours later the baby was born dead; the mother barely pulled through. Had she not been brought to the hospital, her death would have been a certainty . . .

What kind of a person is this nurse-on-horseback? Vanda Summers is alert, cheerful, personable. She wears the Frontier Nursing Service uniform all the time—royal-blue whipcord breeches and jacket, with white waist and black English riding boots. Brown-eyed, dark-haired, almost invariably smiling, she is slender and athletic, looks thirty instead of forty. Her chief pride is in the F.N.S. and its record of only four deaths in 3,000 births. Her crisp Oxford accent has persisted through the nine years she has been surrounded by the soft, slow speech of the Kentuckians, and is taken by them as a matter of course, though they were much amazed and amused by it at first. She keeps a cow, chickens, raises flowers and vegetables in her garden, and owns a nice English setter. The latter she lets chase rabbits, as she "never expects to enter him in field trials." She rarely goes hunting, but often lends the dog to neighbors who repay her with quail.

Red Bird's clinic is roomy and well equipped for routine health inspections and treatment. There Miss Summers holds weekly examinations for the 112 families under her care. Being the only nurse within a hundred square miles, she is the complete health and medical mainstay of this group. And she ministers to all their needs except those which plainly demand hospital, surgical, or specialized diagnostic attention. She also holds regular clinics in six schools in the district, inoculating, treating, and lecturing the children on cleanliness and health rules.

Reading and listening to the radio are among Miss Summers' favorite pastimes. She receives large shipments of the latest biography and fiction, and has two radios (both battery-operated)—one in her living room and one in her bedroom. Her most recent and most amusing hobby is the study of the musical saw, which is played with a violin bow. It sounds, as she puts it, "like an Irish banshee having a bad

night." She heard someone playing the saw at one of the local dances, was amused by it, and bought one.

Another outlet is her painting, at which she is tolerably competent. She works with crayon and water colors, and frequently revises the health posters which are sent to the schools and the outposts by New York agencies and insurance companies. These, she says, are frequently inapplicable to the locale. For instance, an illustration in the "drink-more-milk" poster showed a large bottle of milk being placed on the doorstep by a uniformed dairyman. Trouble was that no one had ever heard of a dairy, had ever seen a milk bottle, and everyone thought the uniformed milkman was a policeman. She substituted a poster of her own painting, showing a mountaineer milking a cow, which impressed the children as being a more logical source of milk than the original design.

Though the Red Bird section of Kentucky is known for its "toughness," the only attack Miss Summers ever sustained was that launched by a patient's dog up in the hills some months ago. The dog bit her on the hand. She simply kept going until she came to the next house where, with the help of its occupants, she dressed the wound with materials from her own first-aid kit. The only SOS she, or any of the frontier nurses send out, is when they can see that a delivery in the mountain cabin is likely to be dangerous, in which case they call in aid for the removal of the patient to the hospital in Hyden.

Relax

[*Continued from page* 20]

pour out a medication. When you're writing charts, your arms are active; but your feet, your body, even your neck to some extent are relaxed. This sort of relaxation is a learned process. It cuts down your energy output enor-

"Goodie-

I HEARD WHAT THE DOCTOR ORDERED"

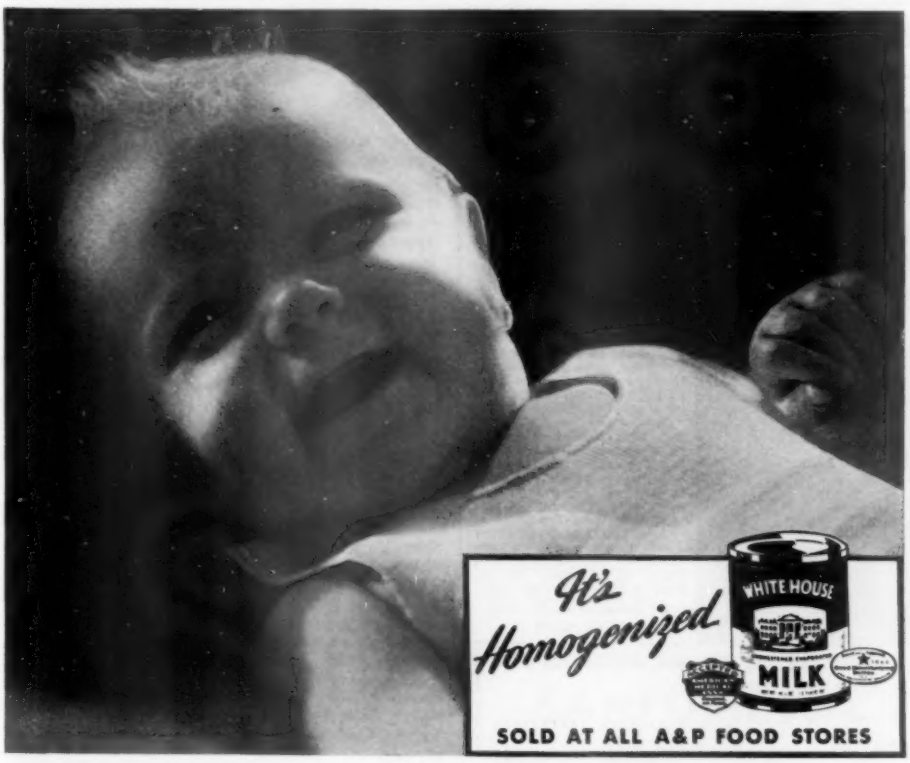
Mother cheered, too, when she realized the thrift assured by an evaporated milk formula

Babies can't talk . . . but they can enjoy the security of an evaporated milk formula when mother's milk fails. It helps so much to avoid gastric and intestinal upsets.

By suggesting White House Evaporated Milk, you also help to avoid extra costs. At any A&P Food Store your patients will find that White House costs less than other high-quality brands.

In quality, White House pleases, too. Accepted by the American Medical Association's Council on Foods. Approved by Good Housekeeping Bureau. Conforms to Government standards with a total solids content average of 25.3% and butterfat content average of 7.84%. Curd tension is 0 (gram). Unbiased laboratory tests report it sterile.

White House is homogenized: the fat particles of ordinary milk are broken into tiny particles and blended evenly throughout. It is also pre-heated, standardized and sterilized, providing a soft, finely-divided, fluid-like curd easily digested and assimilated. Made, sold and guaranteed by A&P. Your patient gets double her money back if she is not 100% satisfied.



mously. It does away with unnecessary fatigue. You do your work better, and you're certainly a more pleasant sight to behold, while doing it.

R.N.'s as a whole are apt to feel a little guilty about taking time out for "doing nothing." But try to put a little time aside for enforced rest each day. It may be one way of keeping your energy up to par throughout the winter.

Where to find our advertisers

"That's enough of that," said the Head Nurse

Head: HERE, here, what's the matter now?

Nurse: Doctor M. complained because I-I wasn't quick enough. This confounded uniform has shrunk so it binds my arms and—and shoulders.

Head: Ye-es, so I noticed. It certainly doesn't add anything to your appearance, either.

Nurse: And I d-d-dropped some instruments. He was mad. Mean, too.

Head: Well, you take a tip from *me*, child. Throw that uniform away, and buy yourself one that's *Sanforized-Shrunk*—like mine!

Nurse: You mean it won't shrink all out of fit—like this thing? Even with all the constant hard washings?

Head: That's exactly what I mean. Sanforized-Shrunk is the *one known process* that controls cotton fabric shrinkage to an insignificant 1%!

Nurse: But-but the man in the store said *this one* wouldn't shrink. He said it was "pre-shrunk." And just look at that hemline—it's up *two inches!*

Head: Well, don't you take any more chances. Buy your uniforms made out of "Sanforized-Shrunk" fabrics as I do, and you'll get along all right with the doctors.

Nurse: Oh, thank you *so* much! I'm going to write it down right now: S-a-n-f-o-r-i-z-e-d-S-h-r-u-n-k. And I'm going to insist on getting it!

For permanent fit, look for the words

SANFORIZED-SHRUNK

INTERESTING PRODUCTS

Here is a check-list on new products and services. You may have samples or literature by writing the manufacturers. The service is available only to registered nurses. Be sure to give your registration number.

METABOLISM APPARATUS: BENEDICT-ROTH equipment is highly scientific yet simple to operate in making accurate basal metabolism tests. It has been extremely popular with hospitals and physicians in private practice for many years. As nurses are being called upon more and more to assist the clinician in this work, a complimentary instruction brochure will be sent to registered nurses addressing Warren E. Collins, Inc., Dept. RN 11-40, 555 Huntington Ave., Boston, Mass.

SKIN AIDS: For 35 years, POSLAM ointment has been used nationally to help annoying skin conditions. It is especially compounded to relieve the itching and burning of eczema, as a local palliative for acne pimples and many other skin discomforts. It soothes raw, irritated skin, minor wounds, and excoriations of the surface. POSLAM soap, used in combination with Poslam ointment, alleviates skin ailments due to external causes. Because Poslam soap is free from excess alkali it will not irritate the most sensitive skin. For free samples of soap and ointment write Emergency Laboratories, Dept. RN 11-40, 254 W. 54th St., New York, N.Y.

BABY FOODS: Do you know when baby may begin to take his first solid food? Do you know what kinds of solids are being recommended by child specialists, and the vitamins and minerals available in this form? These and many other questions important to nurses are answered in two recent booklets issued by the research laboratories of LIBBY, MCNEIL & LIBBY. Expert in the field of canned foods for infants and children, Libby offers homogenized strained vegetables and fruits for the very young child, chopped vegetables and fruits for the child who can chew. These and other Libby baby foods are described in the booklet. For copies write Dept. RN 11-40, Libby McNeil & Libby, Union Stock Yards, Chicago, Ill.

LOTION: Skin irritations and chafing from bedclothes add to any patient's discomfort and hamper his recovery. ZEMO is a clean, stainless liquid combining soothing essential oils with healing medications such as borax and menthol, thymol, boric and benzoic acids, methyl salicylate, phenol, glycerine, 35 per cent alcohol, and other ingredients. Zemo has been found to relieve the itching of eczema and pruritus ani, the distress of athlete's foot, poison ivy, acne, insect bites, chafing, chapping, and sunburn or windburn. Comes in Regular and Extra strength. R.N.'s may have free samples. E. W. Rose Co., Dept. RN 11-40, 1750 E. 27th St., Cleveland, O.

EMULSION: ANGIER'S EMULSION is a non-narcotic, neutral tasting therapeutic aid to relieve the distressing symptoms of cough, irritation, inflammation and congestion of the tracheo-bronchial mechanism when due to colds. It has been successfully used as a supplementary treatment in other simple and difficult respiratory affections as well. The product is advertised solely to the profession. For samples, write Angier Chemical Co., Dept. RN 11-40, 244 Brighton Ave., Boston, Mass.

NEW LAXATIVE: For some time, investigators have noted the relatively frequent relationship between Vitamin B complex deficiency and intestinal atony in constipation. BARAVIT, a new laxative put out by the Schering Corporation, is designed to correct this condition. It provides bulk for direct relief through the use of bassorin. It then follows through with thiamin-reinforced Vitamin B complex to restore muscular tone. For samples and literature address The Schering Corp., Dept. RN 11-40, 86 Orange St., Bloomfield, N.J.

Positions available

ADMINISTRATOR: Graduate nurse to take charge of new private hospital, no training school, to be opened within next six months. Candidates must have had several years' successful experience. (Placement bureau charges $2 registration fee.) Box MB11-1.

ANESTHETIST: California. For one of California's leading hospitals. Salary $150, including board and laundry. (Placement bureau charges $2 registration fee.) Box MB11-2.

ANESTHETIST: South. Large southern hospital, in picturesque city, seeks exceptional qualified nurse with attractive appearance and personality. Salary open. (Placement bureau charges $2 registration fee.) Box C281.

ASSISTANT DIRECTOR: Graduate nurse sought to advance intensive program in nursing education, and instruct in clinical supervision. Bachelor's degree and experience in conducting clinical teaching program essential. School conducts both advanced degree program for graduate nurses and five-year course for students. (Placement bureau charges $2 registration fee.) Box MB11-19.

ASSISTANT DIRECTOR: East. Interesting appointment for nurse with college degree in eastern hospital affiliated with large medical university. Highly desirable location. Salary, $110; maintenance. (Placement bureau charges $2 registration fee.) Box C282.

ASSISTANT EDUCATIONAL DIRECTOR: Municipally owned 500-bed hospital seeks nurse to teach bacteriology, chemistry, history of nursing, psychology. Applicant must have degree and teaching experience; should be 25-30, and capable typist. School averages 120 students, three instructors. Salary, $125; maintenance. Month's vacation following year of service. (Placement bureau charges $2 registration fee.) Box MB11-20.

DIETITIAN: To assist in metabolic diet kitchen of large university hospital. Should be available not later than December 31. (Placement bureau charges $2 registration fee.) Box BM11-3.

***DIETITIAN:** East. Nurse with dietetic experience for 150-bed hospital. Personal interview required. E. M. Rogers, Supt., Eastern Dispensary and Casualty Hospital, 8th and Massachusetts Ave., N. E., Washington, D.C.

DIRECTOR OF NURSES: One of country's leading hospitals for children wants nurse with degree, preferably Master's in nursing. Must be under 40, with some administrative experience. Minimum salary, $200; maintenance. (Placement bureau charges $2 registration fee.) Box MB11-8.

DIRECTOR OF NURSES: Pacific Northwest. Fairly large hospital seeks strict disciplinarian with full knowledge of her duties who has successfully served as director of nurses. Duties will probably include those of assistant administrator. Woman of 45 or 50 preferred. Younger woman eligible. (Placement bureau charges $2 registration fee.) Box MB11-7.

DIRECTOR OF NURSES: West. For university school averaging 125 students. Opportunity to work closely with competent medical administrator with interesting plans for expansion. (Placement bureau charges $2 registration fee.) Box MB11-9.

GENERAL DUTY: Arizona. Well-equipped industrial hospital. Salary, $85; maintenance, plus bonus of 10 per cent. Present salary $93.50. (Placement bureau charges $2 registration fee.) Box MB11-5.

GENERAL DUTY: East. Several nurses for large eastern hospital offering exceptional opportunity for advancement. Ability to assume responsibility. Starting salary, $75; full maintenance. Early increase. (Placement bureau charges $2 registration fee.) Box C287.

***GENERAL DUTY:** East. Immediate opening. Salary, $65; maintenance. E. M. Rogers, Supt., Eastern Dispensary and Casualty Hospital, 8th and Massachusetts Ave., N. E., Washington, D.C.

GENERAL DUTY: South. For large hospital operated under auspices of one of country's leading industrial companies. Opportunity to work into supervisory positions. Salary, $80; maintenance. Yearly increases. (Placement bureau charges $2 registration fee.) Box MB11-6.

***GENERAL DUTY:** New York. Vacancies in private 150-bed hospital for registered nurses qualified to circulate in operating room. Day and night duty. Salary, $75; maintenance. State details fully as to education and experience. Box BC11-40.

GENERAL NIGHT DUTY: South. For south central industrial hospital fairly close to large city. Salary, $90; full maintenance. (Placement bureau charges $2 registration fee.) Box C289.

HEAD NURSE: East. Community hospital in historic New England city wants head nurse for

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Write a separate application for each job in which you are interested.

Address each application to the correct box number, care of R.N. —A JOURNAL FOR NURSES, Rutherford, N.J.

All positions are listed by a placement bureau except those otherwise indicated. Send no money with application. Bureaus requiring a fee will bill you.

**Not listed by a placement bureau.*

male surgical ward, averaging 30 patients. (Placement bureau charges $2 registration fee.) Box MB11-10.

HEAD NURSE: South. Large southern hospital seeks nurse with post-graduate training in ward management and ward teaching. Salary, $100; maintenance. (Placement bureau charges $2 registration fee.) Box C292.

INSTRUCTOR, SCIENCE: South. Non-resident appointment in fairly large hospital. Excellent educational building consisting of classrooms, recreation and demonstration rooms; science laboratory. Teaching staff well organized. (Placement bureau charges $2 registration fee.) Box MB11-11.

LABORATORY X-RAY TECHNICIAN: South. Graduate nurse required to handle lab and X-ray work

in student health service of large southern university. (Placement bureau charges $2 registration fee.) Box MB11-12.

LABORATORY X-RAY TECHNICIAN: West. For small hospital in scenic western location, near Yellowstone Park, offering many climatic advantages. Salary open. (Placement bureau charges $2 registration fee). Box C295.

PUBLIC-HEALTH NURSE: Midwest. Nurse able to drive a car; for opening with middlewestern tuberculosis group. Salary dependent upon qualifications. (Placement bureau charges $2 registration fee.) Box C304.

PUBLIC-HEALTH NURSE: West. To serve as orthopedic supervisory nurse in large district. Will be required to take some responsibility in the cardiac work expected to develop in crippled children's division. Broad experience in supervision required. (Placement bureau charges $2 registration fee.) Box MB11-13.

SUPERINTENDENT OF NURSES: South. Unusually attractive appointment in southern hospital. Candidate must be energetic, adaptable. Pleasant working and living conditions. Salary, $175; maintenance. (Placement bureau charges $2 registration fee.) Box C308.

SUPERVISOR, EYE DEPARTMENT: Supervisor for 40-patient department sought. Responsibilities both administrative and teaching. Students include graduate staff nurses, post-graduate students, undergraduate students. Must have some knowledge of operating-room technique. Large municipal hospital. (Placement bureau charges $2 registration fee.) Box MB11-14.

SUPERVISOR, NEUROLOGICAL WARD: Large teaching hospital seeks neurological supervisor. Must be graduate of large hospital and able to carry on program. Excellent opportunity. (Placement bureau charges $2 registration fee.) Box MB11-21.

SUPERVISOR, OBSTETRICAL: California. Private hospital in residential district wants OBS. Supervisor for department averaging 45 cases monthly. Department is well-staffed. (Placement bureau charges $2 registration fee.) Box MB11-15.

SUPERVISOR, OPERATING ROOM: For active surgical service averaging 20 operations daily in 500-bed hospital, seven operating rooms. Staff includes seven graduate nurses and fifteen students. Salary $135; maintenance. Early increase to $150. (Placement bureau charges $2 registration fee.) Box MB11-16.

SUPERVISOR, ORTHOPEDIC: For well-rated children's hospital. Ability to instruct student nurses in care of crippled children important. Salary open, but probably above average. (Placement bureau charges $2 registration fee.) Box C301.

SUPERVISOR, OUT-PATIENT: East. Good organizer with public-health background required. Rapidly growing department which needs complete reorganization. Community hospital, fairly large, located in historic New England city. Placement bureau charges $2 registration fee.) Box MB11-17.

SURGICAL NURSE: California. Small private, northern California hospital needs surgical nurse. Must be under 30, well-trained and experienced. (Placement bureau charges $2 registration fee.) Box MB11-18.

SURGICAL NURSE: South. Unusually remunerative appointment in south central industrial hospital. Desirable location close to large city. Salary, $100; full maintenance. (Placement bureau charges $2 registration fee.) Box C312.

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Equally important, *Ovaltine* supplies high-quality proteins, quickly absorbable carbohydrates, and emulsified fats. It also helps digest starches and, by softening the curd of milk, makes milk more readily digested.

Therefore, many physicians are now prescribing *new, improved Ovaltine* in cases requiring extra nourishment that is rich in protective food elements, in easily digested form.

A request, over your signature, to The Wander Company, Dept. RN-11, 360 North Michigan Avenue, Chicago, Illinois, will bring you a full-size tin of the new, improved *Ovaltine*. *Your attention is directed to the raw materials used, to the biological assays and analyses on the label.*

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An Aid to the Natural Defense Mechanism . .

WHILE it is obvious that no antiseptic will completely kill all of the bacteria found on the membranes of the upper respiratory tract, nevertheless, many infections of the nose and throat are beneficially treated by the use of a non-toxic, non-irritating antiseptic.

'S.T. 37' Antiseptic Solution is of particular value in these conditions because it possesses high germicidal activity, but at the same time has a very low tissue toxicity. Thus, many of the bacteria are not only killed by chemical means, but the defense mechanism against infection of the tissues themselves is not disturbed. In addition, 'S.T. 37' Antiseptic Solution exerts a mild surface analgesic effect.

Thus, the therapeutic action of 'S.T. 37' Antiseptic Solution is threefold when applied to painfully inflamed tissues such as are found in acute naso-pharyngitis, pharyngitis, tonsillitis and laryngitis:

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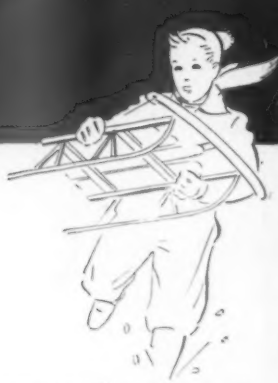

Is winter far away?

UNDER BEAUTIFUL autumnal skies, with the warmth of Indian summer still in the air, we are all too prone to forget that winter can't be far away. And yet, in a few short months we shall be faced with the strains and stresses of winter—with sunless days, curtailed vitamin intake, and increased susceptibility to respiratory infections.

To help their patients prepare for the period of increased vitamin requirement many doctors are ordering Vi-Penta Perles or Vi-Penta Drops for them *now*. These preparations facilitate administration of vitamin supplements in effective, easy-to-take, economical form. Vi-Penta Perles are tiny gelatin globules containing exceptionally high potencies of the 5 principal vitamins—A, B_1, B_2(G), C, and D; Vi-Penta Drops are a concentrated palatable solution of the same 5 vitamins to be added to liquid or solid foods. Patients of all ages can be assured of an adequate vitamin intake by daily Vi-Penta medication. The Perles are intended for adults and older children, the Drops for infants and others who cannot or will not swallow capsules.

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Vi-Penta Perles: *Cartons of 25 and 100; bottles of 250*
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